

# CALIFORNIA TELEHEALTH DEVELOPMENTS AND CHILDREN'S ACCESS TO CARE

## Introduction

While California has made considerable progress in expanding children's health insurance coverage, many continue to face significant barriers to accessing care. In 2019, a report from the state auditor's office found that an annual average of 2.4 million children—more than a third of the children enrolled in the program—do not receive the preventive services to which they are entitled.<sup>1</sup> While almost 90 percent of Medi-Cal enrolled children are in managed care plans, the Auditor found that Medi-Cal managed care plans do not meet time and distance standards. At the same time though, health care technology continues to advance rapidly, providing opportunity for such technology to address access barriers for children.

As a result of technological advancements and lower costs, the adoption of telehealth has become more widespread as a critical tool for improving access to care and health outcomes for children in the state. California has passed extensive telehealth policy reform and has sought to keep pace with the rapidly evolving technology. Policy developments of 2019 are indicative of a growing recognition of the value of telehealth; however, the new regulations do not necessarily work to improve access to care for low-income children and families who need it most.

### California law 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 while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store-and-forward transfers."*<sup>2</sup>



Telehealth provides the opportunity for provider-patient interactions over live video conferencing, store-and-forward, remote patient monitoring, and mobile communication. It has been shown to increase utilization for children, save costs for patients and providers, and improve overall care coordination.

With increased investment in telehealth, California can dramatically improve access to remote care for children across the state, but it will require a child-centered approach to telehealth that has not yet been fully recognized. There remains significant work to be done in California to develop child-centered telehealth policies that address the needs of California's most vulnerable children. This brief focuses on the goal of ensuring access to quality, affordable health care for California's children and examines the developments of this year through a child lens. The brief identifies barriers that persist in realizing the potential of telehealth to serve children and families and offers recommendations for improving child health outcomes using telehealth. We look forward to working with policy-makers, program administrators, and the private sector to expand the reach of telehealth so that California's nine million children can get a healthy start in their lives.



## The California Landscape

Too many children in California lack adequate access to essential health care services, ranking 40th out of the 50 states in providing preventive services.<sup>3</sup> When physical and mental health concerns go unaddressed, common medical issues are more likely to become crises with devastating impacts. Access rates are particularly low in the eastern and northern region of the state, in counties such as Alpine, Mariposa, and Plumas.<sup>4</sup>

The need for increased access to mental health services for youth in California is especially concerning. Data from the California Healthy Kids Survey shows increased rates of depression, anxiety, and suicidal ideation; yet, the majority of children are unable to access counseling or other mental health care services. For the 1.4 million children with special health care needs (CSHCN) in California, their care is complex and may require multiple specialists, coordinated health care, and related services on an ongoing basis from a multidisciplinary set of providers.<sup>5</sup> The health care needs of CSHCN often go unmet due to a variety of reasons, such as provider shortages, lack of access to specialists, lack of affordable transportation, and other barriers. Further, complications related to CSHCN's health care conditions can make it difficult for families to transport their children long distances.

California is also in the midst of a health care workforce shortage. The California Future Health Care Workforce Commission estimates a need of over 4,000 primary care clinicians in the next decade to meet demand.<sup>6</sup> There are numerous programs underway to build the pipeline of clinical providers in the state, but addressing this considerable gap also calls for increased investments to provide care in non-clinical settings and in innovative ways. The Workforce Commission specifically highlights technology as a foundational element for a future workforce and recommends maximizing the role of nurse practitioners to expand care. The Commission highlighted what it refers to as “virtual care technologies,” such as telehealth and remote monitoring, which have

demonstrated the ability to increase access to specialty services in underserved and remote communities.<sup>7</sup> The Commission also noted that research shows such technologies also improve communication between patients and their care teams, enhance patients' engagement in managing their own care remotely, and lower avoidable costs. In maximizing the scope of work of health care professionals, telehealth provides an opportunity for nurse practitioners, medical assistants, and community health workers to play a critical role in reaching more kids outside of clinic walls, particularly in underserved communities.

Finally, considering the context of today's political environment is particularly important when examining access challenges for California's diverse population of children. The current climate of anti-immigrant rhetoric and policy is further hindering access to health care services. The actions of the federal administration have instilled a deep and growing fear around enrolling and accessing health care services, threatening the health and wellbeing of millions of children in immigrant families.<sup>8</sup> Now more than ever, locating services at trusted community sites is essential. It is particularly valuable for telehealth to be accessible at schools, child care centers, churches, and other sites where families feel safe.



## Telehealth Policy Development in California

California was one of the first states to establish telehealth reimbursement through its Medicaid program, as a result of the Telemedicine Development Act of 1996, and in 2011, the state enacted the Telehealth Advancement Act of 2011, which overhauled California's telehealth laws to keep pace with the rapidly evolving technology. Since that time, multiple efforts related to expanding telehealth have helped position the state as a national leader on creating a policy and regulatory environment that is favorable to the adoption

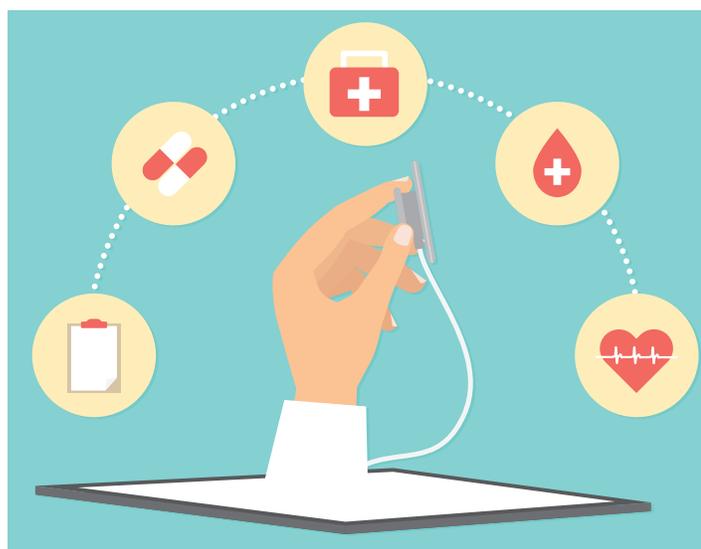
**2.4 million children do not receive the preventive services to which they are entitled.**

Source: “Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services,” March 2019. California State Auditor Report 2018-11.

of telehealth. However, there remains considerable work to be done to ensure telehealth adoption extends equitably to our most vulnerable children.

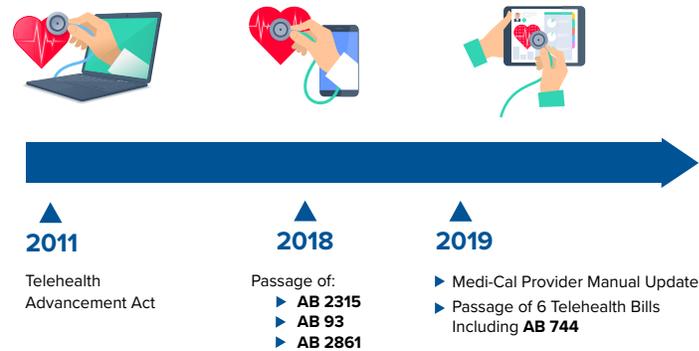
Throughout 2019, California instituted almost a dozen major telehealth-related policy shifts. The year began with three telehealth laws taking effect: AB 2315—sponsored by The Children’s Partnership—which requires the Department of Health Care Services (DHCS) and CDE to create guidelines for the usage of telehealth in schools; AB 93, which added licensed marriage and family therapists to the list of eligible reimbursable providers under telehealth; and AB 2861, which added licensed substance-use disorder counselors and licensed healing arts providers to be reimbursed for telehealth services. However, funding for AB 2315 was not included in the final state budget, preventing its full implementation.

In August, DHCS released its long-awaited telehealth updates to the Medi-Cal provider manual. The majority of the policy change in the manual is directed to fee-for-service providers, with some updates to Managed Care Plans (MCPs); Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs); Indian Health Services (IHS); and the Family Plan, Access, Care, and Treatment (PACT) program.<sup>9</sup>



While the manual update contains some promising developments to clarify providers’ ability to utilize telehealth, the new policies also create barriers that severely restrict the ways in which children, especially the six million children enrolled in Medi-Cal managed care plans, can benefit from telehealth. In the following paragraphs, we summarize key developments and their impact on children’s access to care.<sup>10</sup>

## Timeline of Recent Changes in Telehealth in California



## Promising Developments

### ▶ Clarifying the Definitions of Telehealth Terms

The 2019 provider manual update includes definitions for “e-consult,” “asynchronous store-and-forward,” “originating site,” and “distant site.”<sup>11</sup> Previously, Medi-Cal manuals had not included definitions for these terms. Additionally, the update provides increased flexibility and choice for providers, who can select to provide care using live video or store-and-forward, as long as the service is covered by Medi-Cal and all other legal requirements are fulfilled.

Codifying these definitions in policy and clarifying provider choice in administering telehealth services are important steps forward on the path towards expanding access to care via telehealth for children enrolled in Medi-Cal. While it does not necessarily incentivize Medi-Cal providers to adopt child-focused telehealth programs, it does offer necessary clarifications that provide authorization for moving forward for providers who elect to do so.

### ▶ Including the Patient’s Home as an Originating Site

The “originating site” is the site at which a patient is located while receiving services, such as a community clinic. The manual update for Medi-Cal fee-for-service and managed care now states that “the type of setting may include, but is not limited to, a hospital, medical office, community clinic or the patient’s home.”<sup>12</sup>

This change has the potential to benefit many families who face complex barriers in travelling to appointments, including children with special health care needs. Pilot programs throughout the United States are currently implementing innovative case management and behavioral therapy treatment programs using home telehealth to reach children.<sup>13</sup> However, it is important to note that home telehealth often requires internet access and audio/video equipment that not all families in the state are able to access.

## Challenges

### ► *New Requirements Around Clinic Ability to “Establish a Patient”*

The provider manual includes a requirement that FQHCs and RHCs must “establish a patient” in a face-to-face visit before the clinic is able to bill for telehealth services provided outside of clinic walls. Requiring an initial visit within clinic walls undermines many of the important goals and potential benefits of telehealth for children: eliminating the need for transportation to medical offices, reducing the need for parents and caregivers to take time off work, and increasing the likelihood that issues will be identified early.

This change is already directly impacting teledentistry models that have been serving children, as well as older adults, across California for years. The Virtual Dental Home (VDH) uses store-and-forward technology to provide dental screenings to children at schools and community sites and then connect them to appropriate dental follow-up. VDH sites across California establish students as patients at elementary schools and Head Start sites (not in clinics) and have expanded their reach through the Dental Transformation Initiative. Partnerships between clinics and community agencies, like schools and early learning centers, are critical to bringing care to where children are and addressing access barriers for children. With the new requirements to “establish a patient,” providers across the state that clinics may need to dramatically decrease VDH operations if they are unable to be reimbursed for visits at school sites.



When considering application of these new requirements to other services, the implications of this change are likely to extend to other school-based telehealth offerings as well. For example, school-based mental health programs are specifically designed to connect youth with mental health professionals without their needing to visit clinics.

### ► *Lack of guidance and incentives for Managed Care Plans (MCPs)*

Almost 60% of California’s children are enrolled in Medi-Cal. However, the provider manual updates and accompanying guidance are directed primarily toward fee-for-service providers although the overwhelming majority of children in the Medi-Cal program are enrolled in MCPs. There is little incentive within these policies for MCPs to increase their telehealth adoption, meaning that many children enrolled in Medi-Cal are unlikely to benefit from telehealth updates. There is also a lack of guidance and no clear requirements of health plans around reporting on telehealth utilization. Without reporting mechanisms, the state cannot assess how telehealth is or is not impacting coverage rates. A lack of data will have implications on future efforts to improve telehealth adoption or delivery for Medi-Cal enrolled children.

## New Legislation Signed by Governor Newsom

In September 2019, Governor Gavin Newsom signed six telehealth-related bills into law,<sup>14</sup> including Assembly Bill 744, a law that establishes payment parity for services provided via telehealth by private providers. The law has garnered national attention for being one of the first of its kind; however, its exclusion of Medi-Cal creates serious concerns of equitable access to care. Advocates across California have expressed concern that this new law reinforces existing disparities between individuals enrolled in private insurance and those enrolled in Medi-Cal. For the millions of California children enrolled in Medi-Cal MCPs, this policy does not go far enough to support access to timely and quality care. Without payment parity extending to Medi-Cal MCPs, it is unlikely that telehealth development will be prioritized and widely adopted to serve the children most in need of services. Almost 60% of California’s children are enrolled in Medi-Cal. However, the provider manual updates and accompanying guidance are directed primarily toward fee-for-service providers although the overwhelming majority of children in the Medi-Cal program are enrolled in MCPs. There is little incentive within these policies for MCPs to increase their telehealth adoption, meaning that many children enrolled in Medi-Cal are unlikely to benefit from telehealth updates. There is also a lack of guidance and no clear requirements of health plans around reporting on telehealth utilization. Without reporting mechanisms, the state cannot assess how telehealth is or is not impacting coverage rates. A lack of data will have implications on future efforts to improve telehealth adoption or delivery for Medi-Cal enrolled children.

## Recommendations

Telehealth continues to have the potential to improve the lives of children and their families, while strengthening the capacity of health care providers and the health care system to connect with community partners to better serve their patients. However, if the challenges to telehealth adoption are not addressed, this important tool will not fulfill its potential. The following recommendations offer strategies to ensure telehealth is integrated into health care and support systems for children and their families.

- ▶ **Revise Medi-Cal Policy to Allow Clinics to Establish a Patient Using Telehealth.** As the state auditor’s report outlined, access to care for children enrolled in Medi-Cal is severely limited. Remediating this will require a menu of policy reforms, which should include incentivizing plans to use technology to reach patients remotely and allowing providers and FQHCs to work with schools and community sites.

The Department of Health Care Services—or alternatively, the California legislature—should remove the requirement that clinics must first establish a patient in a face-to-face visit to be eligible for reimbursement for services rendered via telehealth. This new policy is already negatively impacting children’s access to oral health services and is likely to limit the adoption of telehealth more broadly in school-based health centers and other community sites. As research on the health care workforce shortage and on the “chilling effect” of current immigration policy shows, families need increased access to care outside of clinic walls.

- ▶ **Fully Implement School-Based Telehealth for Mental Health Laws.** Supporting school-based telehealth is an opportunity to leverage an evidence-based model with benefits for children, educators, and entire communities. Telehealth programs in schools and at childcare sites have been shown to improve access to care, student health outcomes, school attendance, and academic performance. Additionally, they provide an opportunity to support working families who might otherwise have to take time off work or lose wages to travel to appointments.

The state should include funding for AB 2315 to fully implement the law and lay the groundwork for greater adoption of telehealth in school settings. Various barriers continue to limit widespread adoption of telehealth in education settings, including technological, legal, administrative, and licensing barriers.<sup>15</sup> While educators have continued to voice their needs for increased support of student mental health, schools are not fully equipped to meet these needs without guidance and support at the state level. Utilization of telehealth may provide a partial solution to offering critical services to students on campus, and AB 2315 would support schools interested in exploring such an opportunity. The Department of Finance estimates the cost of AB 2315 to be \$300,000, for which the Department of Health Care Services and the Department of Education can convene a workgroup to create the guidelines for school-based telehealth for mental health services.

- ▶ **Extend Payment Parity to Telehealth Rendered in Medi-Cal Managed Care Plans.** Currently, the state is not fully supporting the adoption of telehealth designed specifically to serve low-income and vulnerable populations. Without sustainable funding streams and reimbursement rates equal to those provided for in-person visits, providers serving children enrolled in Medi-Cal are not incentivized to widen their telehealth offerings.

The changes to reimbursement for private providers established in AB 744 should be applied to Medi-Cal Managed Care Plans. Without parallel policy change to payment for services in Medi-Cal, disparities between children enrolled in Medi-Cal and those enrolled in private insurance are likely to widen. In order for telehealth to help move us closer to statewide goals of improving access to health care for children in Medi-Cal, Managed Care Plans will need to receive adequate reimbursements for services provided using telehealth.

As advancements in technology continue and adoption of telehealth becomes ubiquitous, this era provides a tremendous opportunity to ensure that children, particularly low-income and underserved children, across California benefit from these developments. Through a focused policy agenda, we can remove geographic and economic barriers to high-quality health care for children and families. With the investment from policymakers, health care systems, communities, and other stakeholders, California can maximize appropriate and widespread use of telehealth to improve the overall health of California’s children.

# Acknowledgements

*Funded by a grant from the Lucile Packard Foundation for Children's Health, Palo Alto, California.*

The Children's Partnership (TCP) is grateful to the Lucile Packard Foundation for Children's Health for the support of the development and production of this brief and to the California Health Care Foundation for its ongoing support of TCP's broader advocacy agenda for children.

## Endnotes

<sup>1</sup> "Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services," California State Auditor Report, March 2019, 2018-11.

<sup>2</sup> California Business and Professions Code, Sec. 2290.5.

<sup>3</sup> "Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services," California State Auditor Report, March 2019, 2018-11

<sup>4</sup> Ibid.

<sup>5</sup> "Realizing the Promise of Telehealth for Children with Special Health Care Needs," The Children's Partnership, UC Davis School of Medicine, and the Center for Connected Health Policy, September 2015,

<https://www.childrenspartnership.org/research/realizing-the-promise-of-telehealth-for-children-with-special-health-care-needs/>

<sup>6</sup> *Meeting the Demand for Health: Final Report of the California Future Healthcare Workforce Commission*. February 2019, <https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf>.

<sup>7</sup> Ibid.

<sup>8</sup> "Healthy Mind, Healthy Future: Promoting the Mental Health and Wellbeing of Children in Immigrant Families," The Children's Partnership and the California Immigrant Policy Center, 2018,

<https://www.childrenspartnership.org/research/healthy-mind-healthy-future-promoting-the-mental-health-and-wellbeing-of-children-in-immigrant-families/>.

<sup>9</sup> For purposes of this brief, we use the terms "clinic" and "health center" throughout.

<sup>10</sup> For additional descriptions and details on the provider manual updates, see the August 2019 Medi-Cal Telehealth Updated Policy fact sheet from the Center for Connected Health Policy,

[https://www.cchpca.org/sites/default/files/2019-08/Medi-Cal%20Fact%20Sheet%20FINAL\\_0.pdf](https://www.cchpca.org/sites/default/files/2019-08/Medi-Cal%20Fact%20Sheet%20FINAL_0.pdf).

<sup>11</sup> "Medi-Cal and Telehealth," California Department of Health Care Services.

<sup>12</sup> "Medi-Cal Provider Manual: Telehealth," California Department of Health Care Services, August 2019.

<sup>13</sup> "MNLEND Fellows Use Telehealth to Serve Rural Children with Developmental Disabilities," University of Minnesota Institute on Community Integration, April 13, 2018, <https://ici.umn.edu/news/telehealth>.

<sup>14</sup> Assembly Bill 1264, Assembly Bill 1494, Assembly Bill 1519, Assembly Bill 1642, and Senate Bill 24 were also signed by Governor Newsom in 2019. For additional details on the bills, see CAleginfo.com.

<sup>15</sup> B. L. Burke & R. W. Hall, "Telemedicine: pediatric applications," *Pediatrics* (2015), 136(1), e293-e308,

<https://pediatrics.aappublications.org/content/pediatrics/136/1/e293.full.pdf>.