

Advancing California's Leadership in Telehealth Policy

A Telehealth Model Statute & Other Policy Recommendations



Center for
Connected
Health Policy

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Participation in the Work Group and review of this report does not imply endorsement of specific recommendations or the Telehealth Model Statute on the part of any individual or his/her organization.

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About CCHP

Established in 2008 by the California HealthCare Foundation, the Center for Connected Health Policy (CCHP) is a non-profit planning and strategy organization working to remove policy barriers that prevent the integration of telehealth technologies into California's health care system. CCHP conducts objective policy analysis and research, develops non-partisan policy recommendations, and manages innovative telehealth demonstration projects.

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Executive Summary

In 1996, California passed one of the first telemedicine laws in the country, the Telemedicine Development Act of 1996 (TDA). At its passage, the TDA propelled California into a position of national leadership on telemedicine policy, giving credence to telemedicine as a legitimate means of providing health care services. The original intent of the TDA, as captured in the legislative language below, is as timely today as when it was first written 15 years ago.

“The use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care in rural and other medically underserved areas.”¹

The goals of the TDA—to reduce costs, improve quality, and increase access—are even more urgent today. California faces the 2012 fiscal year with a \$25 billion deficit, the latest

The goals of the Telemedicine Development Act—to reduce costs, improve quality, and increase access—are even more urgent today.

in a series of fiscally dire budget crises. In addition, California must contend with medical inflation outstripping general inflation,² shortages of health care providers, and an unequal distribution

of specialists throughout the state.³ Telehealth technologies can serve as tools to expand the delivery of high-quality, efficient medical care.

This report puts forth a Model Statute, developed by the Center for Connected Health Policy (CCHP). CCHP convened a diverse group of 25 prominent health care professionals to serve on its Telehealth Model Statute Work Group. Over a year’s time, Work Group members studied and debated current California policies, available research, and experience from the field, and helped hone recommendations for the Model Statute.

The Model Statute represents a platform for the ideal California telehealth policy environment, and sets aside constraining fiscal, economic, and political considerations. It should be acknowledged that there was not unanimous consensus among the Work Group members on all of the recommendations presented in this report. While this report reflects the Work Group’s deliberations, CCHP assumes full responsibility for its content. Work Group members participated as individuals; neither they nor their respective organizations were asked to endorse the policy proposals presented here.

The proposed Model Statute is a revision to California’s visionary TDA, which focused on expanding coverage of interactive telemedicine services by private and public insurers. In 1996, policy makers feared patient resistance to telemedicine, on the one hand, and overuse of services on the other. These concerns led to TDA provisions, and subsequent regulations, that have become barriers to the use of telehealth. CCHP’s assessment of current telehealth practice, research findings, and other states’ policies, found high patient satisfaction with telehealth, and no indication of over-utilization of telehealth services. CCHP concluded that existing policy barriers to the spread of telehealth need to be eliminated.

The Model Statute proposes changes to existing law and key policy areas, where CCHP believes the state has the most leverage to promote telehealth use to the greatest benefit. The statutory changes included in the report update the TDA, by broadening the type of technologies covered, encouraging more consistent payment policies, reducing administrative burdens on providers, and incorporating telehealth into aspects of state workforce laws. There are other policy recommendations made in the report that do not require changes in law, but would aid the state in the quest to expand adoption of telehealth technologies. CCHP encourages policy makers interested in sponsoring legislation to adopt all or portions of the recommendations contained in the Model Statute.

Summary List of Telehealth Model Statute Recommendations

Redefine Telemedicine as Telehealth and Remove Existing Restrictions

- 1A. Update the term “telemedicine” used in current law to “telehealth” to reflect changes in technologies, settings, and applications, for medical and other purposes.
- 1B. Include the asynchronous application of technologies in the definition of telehealth and remove the 2013 sunset date for Medi-Cal reimbursement of teledermatology, teleophthalmology, and teleoptometry services.
- 1C. Remove restrictions in the current telemedicine definition that prohibit telehealth-delivered services provided via email and telephone.
- 2A. Specify that any service otherwise covered under standard contract terms (e.g., covered benefit, medically necessary) must be covered, whether provided in-person or via telehealth.
- 2B. Eliminate the current Medi-Cal requirement to document a barrier to an in-person visit for coverage of services provided using telehealth.
3. Require private health care payers and Medi-Cal to cover encounters between licensed health practitioners and enrollees irrespective of the setting of the enrollee and provider(s).
4. Remove the requirement necessitating an additional informed consent waiver be obtained prior to any telehealth service being rendered.

Incorporate Telehealth into State Workforce Law

5. Require the Office of Statewide Health Planning and Development (OSHPD) to develop and implement a plan to provide greater visibility for the State Health Workforce Pilot Project (HWPP), and require that OSHPD prioritize HWPP projects that utilize telehealth.
6. Require OSHPD to receive assurances that each program receiving Song-Brown funds includes training on uses of telehealth to expand access to, and increase the efficiency of, needed care; and train prospective health professionals in the use of telehealth technologies, to the greatest extent possible.
7. Require OSHPD to incorporate mechanisms into loan repayment programs that assure that telehealth technologies are being used to expand access to health care to underserved Californians. Certification criteria for approved sites and selection criteria for applicants should reflect the state's desire to maximize the use of telehealth technologies to the benefit of Californians with difficulty obtaining health care.

Other Statutory Recommendations

8. Require telehealth equipment and software vendors who seek to contract with the State of California to show that their products comply with current telehealth industry interoperability standards.
9. Require CalPERS to include telehealth services information in health benefits collateral materials for all beneficiaries.

Other Policy Recommendations

1. Require the state Legislative Analyst's Office to conduct a study to identify the most promising practices using telehealth-delivered care that could benefit Medi-Cal and other state-financed health programs.
2. Require state activities related to Health Information Technology/Health Information Exchange (HIT/HIE) to explicitly include telehealth advocate representation.
3. Require practitioners providing volunteer health services via telehealth to be included in any legislation that allows for malpractice coverage to volunteers providing health services.
4. Require malpractice insurance vendors and professional societies to educate practitioners regarding their options for malpractice coverage for telehealth services.

I. Introduction

In 1996, California passed one of the first telemedicine laws in the country, the Telemedicine Development Act of 1996 (TDA). At its passage, the TDA propelled California into a position of national leadership on telemedicine policy, giving credence to telemedicine as a legitimate means of providing health care services.⁴ The original intent in the TDA, as captured in its legislative language below, is as timely today as when it was first written 15 years ago.

“The use of telecommunications to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care in rural and other medically underserved areas.”⁵

The goals of the TDA—to reduce costs, improve quality, and increase access—are even more urgent today. California

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Telemedicine
Development Act of 1996

faces the 2012 fiscal year with a \$25 billion deficit, the latest in a series of fiscally dire budget crises. In addition, California must contend with medical inflation outstripping general inflation,⁶ shortages of health care providers, and an unequal distribution of specialists.⁷ Telehealth

technologies can serve as tools to expand the delivery of high-quality, efficient care.

Fortunately, thanks to a combination of state, federal, foundation and other investments, California has developed a great deal of capacity to expand telehealth use. For example, the Federal Communications Commission committed \$22 million to The California Telehealth Network, which is connecting more than 800 California health care providers

in underserved areas to a state and nationwide broadband network dedicated to health care. Also, the five University of California campuses and 40 safety net clinics are participating in a demonstration project to provide specialty care in six key medical specialties, via telehealth technologies, to safety net patients. Telehealth technologies improve access, quality of care, and cost savings in a variety of care settings, to a broad spectrum of patient populations. Examples include:

- Live, two-way interactive videoconferencing that connects the patient, primary care provider and specialist for specialty care collaboration;
- Tele-ICUs, which link provider teams and patients at multiple remote sites through video conferencing to bring timely, highly specialized care to the patient, and support to local clinicians;
- Monitoring systems that help persons with chronic conditions in their home, school, or work place;
- Digital images and structured patient interviews that can be uploaded and transferred to distant medical specialists for consultation;
- Patients and caregivers meeting online with trained facilitators to share solutions for better health and care management;
- A virtual dental home project in California that connects dentists in dental offices and clinics with allied dental personnel working in schools, head start centers, group homes, nursing homes, and community centers, for low-income and underserved populations.

Many of these projects and initiatives have struggled to survive beyond their initial demonstration phase. Reasons include the uncertainty of payment for services, difficulties in developing and sustaining provider networks, the challenge of integrating technology among providers, and lack of training resources.

To help state policy makers assess California’s current telehealth policy environment, and identify specific opportunities for change, the Center for Connected Health Policy (CCHP) launched an effort in 2009 to identify policy barriers to telehealth adoption in California. CCHP’s work builds on previous efforts by the California Telemedicine and eHealth Center.

CCHP’s efforts included:

- Analyzing current California telehealth laws;
- Conducting a scan of state and national literature on telehealth policy;
- Holding key informant interviews of practitioners, industry experts, and other telehealth professionals;
- Reviewing telehealth laws in select leading states.

CCHP’s research pointed to the pressing need to review and update the TDA, and to consider new statutes and regulatory changes to encourage more robust adoption of telehealth technologies in California.

In the years since its passage, the TDA has kept pace somewhat with other states—many of which modeled their telehealth laws after it. However, in certain key areas, the California statute has become outdated. Moreover, some components of California law may actually hinder the uptake of telehealth in both the public and commercial sectors, blunting its effectiveness and reach.

Additionally, the March 2010 passage of the federal Patient Protection and Affordable Care Act (ACA) established mechanisms that will put coverage within reach of approximately 94 percent of all Californians. It is estimated that approximately 2 million or more enrollees will be added to the state Medi-Cal program.⁸ The need for providing care for so many, in a time of limited resources, was also a consideration for CCHP in its efforts.

Telehealth Model Statute Work Group

These findings prompted CCHP to initiate a process to create a Telehealth Model Statute. In this effort, model legislative language, and the rationale behind it, was developed for state policy makers, in an effort to remove barriers to the use of telehealth as an integral part of the health care system. In addition, CCHP identified policies that would be most likely to promote greater use of telehealth technologies, to maximize their benefit to Californians.

In early 2010, CCHP convened a diverse group of 25 prominent health care and policy professionals to participate in a Telehealth Model Statute Work Group (see Acknowledgments, for a full list of Work Group members).

The Work Group’s vision for the Model Statute was two-fold: that it support the integration of telehealth as a tool into health care delivery systems; and that it help reshape California’s health care delivery system into a “safe, timely, efficient, equitable, effective, and patient-centered system.”⁹

Work Group members identified three overarching policy goals to support their vision, and to help guide discussions:¹⁰

1. To create **parity** of telehealth among health care delivery modes;
2. To actively **promote** telehealth as a tool to advance stakeholders’ goals regarding health status and health system improvement;
3. To create **opportunities and flexibility** for telehealth to be used in new models of care and in system improvements.

Work Group members analyzed and debated a set of wide-ranging proposals for the Model Statute. CCHP staff and consultants developed recommendations based on Work Group discussions. It should be acknowledged that there was not unanimous consensus among Work Group members on all of the recommendations presented in this report. While

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This Model Statute reflects the findings from CCHP research and the best thinking of policy experts and practitioners. It represents a statutory framework for an ideal California telehealth policy environment, and sets aside constraining fiscal, economic, and political considerations. Policy makers interested in sponsoring legislation may wish to adopt all or portions of the recommendations contained in the Model Statute.

This report contains 13 policy recommendations, nine for inclusion in a Telehealth Model Statute, and four others that CCHP found to be worthy of inclusion, but not appropriate for a Model Statute. Each policy recommendation includes a supporting rationale, for a full understanding of the thinking behind the recommendation. Where applicable, Medicare policy is noted, as are approaches taken in other states.

The report and its recommendations are organized as follows:

- Section II presents the revisions to the TDA, focusing primarily on financial incentives and informed consent;
- Section III incorporates telehealth into state workforce law;
- Section IV contains two additional statutory recommendations to promote interoperability of technology and consumer education;
- Section V contains the four recommendations not included in the Model Statute. These issues can be addressed in other legislation, regulations, or practice;
- A set of three Appendices, which includes The Work Group's Charter, suggested legal language for the Telehealth Model Statute, and a glossary of terms in the report.

II. Redefine Telemedicine as Telehealth and Remove Existing Restrictions

This section includes recommendations that update the TDA by redefining “telemedicine” as “telehealth,” and removes other restrictions to its use in existing state law. California law and Medi-Cal regulations contain barriers to the state garnering the fullest possible benefit from telehealth. While these restrictions served a

Model Statute Definition of Telehealth

Telehealth is a mode of delivering health care services and public health that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients, at a distance from health providers. Telehealth allows services to be accessed when providers and patients are in different physical locations, facilitates patient self-management and caregiver support for patients, and includes synchronous and asynchronous interactions.

purpose in 1996, when use of telemedicine was relatively new, they have become outdated and cumbersome.

Fifteen years later, telemedicine use has not resulted in increased health care expenditures, and consumers have been as satisfied or more satisfied with technology-supported services, when compared with usual care. In fact, recent studies have found that new telehealth applications such as remote patient monitoring

have reduced overall costs, and improved health outcomes for target populations.¹¹

Another concern at the time of the TDA’s passage was that local delivery systems and economics would be harmed by telemedicine.¹² That did not occur. In fact, local communities benefited from telehealth because patients did not have to travel for specialty services. Rather, such services could be received using telehealth, allowing primary care and other services to be maintained in their respective communities.¹³ Additionally, local providers gained support and learned new

skills from distant clinicians, which would then benefit future local patients.¹⁴

CCHP recommends that the state set policy, through statute, that allows greater flexibility to integrate new technologies into health care delivery and payment mechanisms. Health care providers working within their scope of practice should have the ability to choose the most appropriate method of delivering health services to their patients. Telehealth is simply another option of treatment that should be available for the practitioner to use. Removal of barriers in existing law and regulation and easing payment restrictions will encourage the greater use of these modalities, resulting in more efficient and effective use of all services, whether provided in-person or virtually.

Recommendation 1A

Update the term “telemedicine” used in current law to “telehealth,” to reflect changes in technologies, settings, and applications, for medical and other purposes.

Rationale

Under current law, “*telemedicine*” means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes ‘telemedicine’ . . . ‘interactive’ means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.”¹⁵

This definition restricts the statute to medical care and education using interactive technologies. It does not fully

reflect advances in technologies that allow for their use outside of traditional clinical settings. Telehealth is valuable for public health surveillance and delivery, patient and caregiver education/support, and other non-medical uses. The proposed Model Statute definition of telehealth is meant to accommodate changes in technology, health services, and payments. It is intended to be broad and encompassing, and emphasizes that telehealth is a **means of delivery** or set of tools. Coverage or reimbursement is tied to specific services, and telehealth should be viewed as one option for delivering services. Further, services delivered via telehealth should be broadly viewed to include the full range of health-related services, for example, dental and behavioral health.

The proposed telehealth definition allows for new models of care, and new varieties of interaction between clinicians and patients. Telehealth facilitates collaborative care management when patients, providers, and other caregivers are in different locations. This definition also allows for health care services to take place outside traditional provider schedules. With store and forward technologies, for example, a primary care provider (PCP) sends digital images and other medical information electronically to a specialist. The specialist reviews the information and sends the PCP an initial consult (also electronically) without having to set up an appointment with the PCP or the patient.

Recommendation 1B

Include the asynchronous application of technologies in the definition of telehealth and remove the 2013 sunset date for Medi-Cal reimbursement of tele dermatology, teleophthalmology, and teleoptometry services.

Rationale

Current California law creates confusion among payers and providers, because of its imprecise language and differing coverage requirements across payers. This is particularly true in the legal treatment of store and forward, or asynchronous, applications.

The Business and Professions Code is unclear as to the meaning of “*near real time (asynchronous) two-way transfer of medical data and information*,”¹⁶ and thus is subject to different interpretations. As evidence began to show improved patient access to specialists utilizing store and forward technologies, the Welfare and Institutions Code was amended to allow Medi-Cal reimbursement for teleophthalmology and teledermatology.¹⁷

In 2009, the definition of teleophthalmology and teledermatology store and forward services was expanded to include optometrists trained to diagnose and treat eye diseases.¹⁸

However, reimbursements for these services have a sunset date of Jan.

1, 2013. The original sunset date has been extended twice, with AB 354 (Cogdill) in 2005, and AB 2120 (Galgiani) in 2008.¹⁹ Both the extension and expansion are recognition of the merits of these services and therefore should be permanently codified.

Under the Welfare and Institutions Code, telemedicine reimbursement is “*subject to reimbursement policies developed by the Medi-Cal program*.”²⁰ Medi-Cal currently limits what is reimbursable for store and forward to specific specialties.²¹ These restrictions have had an impact on other payers in California. Several private payers now follow the same coverage rules as Medi-Cal.²² However, many additional specialties lend themselves favorably to this technology. For example, CCHP’s Specialty Care Safety Net Initiative includes 40 California safety net clinics, which receive asynchronous services from University of California providers in dermatology, endocrinology, hepatology, orthopedics, and

Store and Forward (Asynchronous) Technologies

These technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos.

Data is collected, or stored, at one site, by an originating provider. The data is then sent electronically, or forwarded, to a specialist, who evaluates the data, and provides an assessment and/or treatment recommendations to the originating provider, without the need for the patient to be present.

psychiatry. Failing to cover store and forward technologies restricts consumers' timely access to necessary care.

Store and forward applications allow more flexibility in data assembly and review than interactive sessions with patients. Many providers report that this flexibility is more convenient for patients, as well as providers, and may be more cost effective than other telehealth technologies, or in-person visits.²³ Expanding the use of store and forward services could increase access to specialists and alternative therapies for rural and underserved populations, and allow providers to more easily seek input on complex cases from specialists. Including asynchronous applications of technologies in the legal definition of telehealth recognizes technological advances that allow important diagnosis and treatment recommendation to be made without the patient being present.

Medicare and Other States' Policies

Medicare allows payment for services provided through store and forward in demonstration programs in Hawaii and Alaska.²⁴ Additionally, Medicare allows payment for some services provided through store and forward technologies, but does not explicitly identify them as "telehealth." For example, the largest single specialty providing remote services is radiology. The use of telecommunications in delivering pathology, cardiology, physician team consultations, and other services in a manner similar to store and forward, is also reimbursed by Medicare.²⁵

Medicaid programs in Arizona, Georgia, Wisconsin and Minnesota all cover the use of store and forward technologies, regardless of the service provided. Arizona and Georgia reimburse for store and forward use in all specialties.²⁶ ²⁷ Wisconsin requires providers to submit a state plan for telehealth, and become certified to provide the service, while Minnesota treats store and forward consults the same as video conferencing, but limits coverage to no more than three consults per enrollee per week.²⁸

Recommendation 1C

Remove restrictions in the current telemedicine definition that prohibit telehealth-delivered services provided via email and telephone.

Rationale

The TDA excluded the use of the telephone or email from the definition of "telemedicine."^{29,30,31} At the time, reasons behind this policy varied. Some feared rampant fraud and abuse; others thought it too cumbersome to define what would constitute a reimbursable service. Medi-Cal and some private payers do not include telephone and email services. However, there are a growing number of private payers that do reimburse for such services.

Both patients and providers benefit from reduced travel and wait times, and communication does not have to be limited to time-certain appointments. Surveys have shown that patients have an increased desire to be able to communicate with their providers through email, and the positive impacts this would have on patient outcomes, patient-provider relationships, and efficiency.³²

With advancements in smart-phone technologies, where video consultations could take place via a phone call, providers need the flexibility to utilize these technologies and be compensated for them.

This recommendation supports removing these restrictions for the purposes of:

- Keeping pace with rapid technological advancements;
- Reducing bias among providers to use certain technologies because they are reimbursed and others are not;
- Providing flexibility when equipment fails.

In expanding the legal definition of telemedicine to telehealth, policy shifts from a limiting, narrow focus on interactive video consultations to services provided remotely by various telecommunications technologies. The proposed legal changes aim to focus payers' coverage decisions on the service delivered, not on the tools used to deliver that service. Payers may of course prescribe parameters, for example, regarding what constitutes a phone or e-mail visit.

Recommendation 2A

Specify that any service otherwise covered under standard contract terms (e.g., covered benefit, medically necessary) must be covered, whether provided in person or via telehealth.

Recommendation 2B

Eliminate the current Medi-Cal requirement to document a barrier to an in-person visit for coverage of services provided using telehealth.

Rationale

Similar to the preceding recommendations, the central policy premise behind these recommendations is that providers working within their scope of practice should have the ability to choose the most appropriate method of delivering health services to their patients. These two proposed changes in California law are intended to make clear that telehealth is a mode of care delivery, and as such, should be treated similarly to other proven modalities. The proposed Model Statute provisions provide a framework for telehealth payment policy that is broad enough to encompass new technologies as they develop, and avoids placing telehealth at a disadvantage by imposing administrative documentation requirements. The first provision is more direct than the current statute, which prohibits payers from requiring in-person contact in the provision of a health care service.³³ Current statute wording, “*appropriately provided through telemedicine,*” which can be used by payers to limit coverage,^{34,35} is eliminated. Replacing the current TDA coverage requirements with a more direct, comprehensive provision will reduce confusion and uncertainty for both providers and consumers over coverage and payment for telehealth services. Although coverage for specific services may vary by payer, a clearer and more consistent policy context concerning the delivery of those services through telehealth should lead to increased provider and consumer adoption of these tools.

The second proposed provision recommends removal of a Medi-Cal regulation that requires providers to justify the use of telehealth-delivered services. Under this regulation,

providers must complete a separate form explaining why the patient cannot receive services in person, thus necessitating the use of telehealth tools.³⁶ While Medi-Cal could eliminate this regulatory requirement, it has not done so, and CCHP recommends it for inclusion in statute to ensure its removal.

The regulation is administratively burdensome and, at least initially, led to significant payment delays, as telehealth claims were “flagged” for separate review. This discouraged use of telehealth services. Some claimants may not have submitted billing claims at all for telehealth services, given the associated costs of doing so. This defeats a key purpose of the required documentation, as Medi-Cal could be hindered in tracking and assessing use of telehealth services. According to Medi-Cal staff, it appears that Medi-Cal telehealth documented claims to date are likely underestimated.³⁷

Other States' Policies

This recommendation is similar to a statute in the State of Maine, which reads, “*A carrier offering a health plan in this State may not deny coverage on the basis that the coverage is provided through telemedicine if the health care service would be covered were it provided through in-person consultation between the covered person and a health provider. Coverage for health care services provided through telemedicine must be determined in a manner consistent with coverage for health services provided through in-person consultation.*”³⁸ The state of New Hampshire modeled the language used in its telehealth coverage bill after the Maine law.³⁹

Recommendation 3

Require private health care payers and Medi-Cal to cover encounters between licensed health practitioners and enrollees irrespective of the setting of the enrollee and provider(s).

Rationale

Payer limits on the setting where services delivered by telehealth must occur (provider offices, clinics, etc.) greatly curtail the use of technology. Inconsistent payer restrictions

on care settings for telehealth have led to confusion among providers regarding coverage. As long as quality standards for a service are met, the physical location of the patient and provider should not matter.

This provision gives discretion to the provider, who as the licensed health care professional, is ultimately responsible for the care of the patient. It is intended to acknowledge:

- The great advantage of telehealth to be able to take services to where the patient is located;
- The importance of telehealth delivery in urban as well as rural settings.

The TDA does not place limits on originating sites, except that they be licensed: “Facilities located in this state including, **but not limited to** clinics, hospitals, and skilled nursing facilities to be utilized by the plan shall be licensed by the State

Department of Health Services, where licensure is required by law.” (Emphasis added.)⁴⁰

Also, the TDA does not mention specifically that services should be limited to rural areas.

Despite the flexibility in state law, some private

payers in California use the same originating site restrictions for payment as Medicare,⁴¹ limiting coverage to areas outside Metropolitan Statistical Areas (MSAs) and requiring services to be provided in a limited set of facilities. The Medicare facilities are:

- Practitioner offices
- Hospitals
- Critical Access Hospitals (CAHs)
- Rural health clinics
- Federally Qualified Health Centers (FQHCs)
- Skilled Nursing Facilities (SNFs)
- Hospital-based renal dialysis centers
- Community mental health centers⁴²

Medi-Cal does not restrict payment to originating sites based on geography or urban/rural designations, but has a more limited site list than Medicare. The Medi-Cal handbook lists as originating sites:

- Physician or practitioner offices
- Critical Access Hospitals (CAHs)
- Rural health clinics
- FQHCs⁴³

In addition to allowing for a more expanded list of licensed sites, this provision would allow providers and patients to deliver and receive care from other locations, such as the home. Unlike some commercial payers, Medi-Cal prohibits providers from rendering telehealth services from their homes.⁴⁴ This has resulted in some Medi-Cal providers, notably those offering store and forward services, refusing to provide telehealth services to Medi-Cal beneficiaries.⁴⁵ This provision will ensure that Medi-Cal patients have access to telehealth services that is comparable to commercial plan enrollees.

Other States’ Policies

Two other states have taken similar approaches to the proposed Model Statute provision. Oregon offers a list of originating sites, but eligible sites are not limited to what is listed. New Mexico offers a list of originating sites that is more extensive than Medi-Cal, but not as broad as Oregon.

Oregon’s 2009 telemedicine law defines “originating site” as the physical location of the patient receiving a telemedical health service, **including but not limited to:**

- Hospital
- Rural health clinic
- FQHC
- Physician office
- Community mental health center
- SNF
- Renal dialysis center
- Sites where public health services are provided

The law further states that a plan may not distinguish between originating sites that are rural and urban in providing coverage.⁴⁶

In addition to those sites allowed in the Medi-Cal program, New Mexico's Medicaid program authorizes the following originating sites:

- All hospitals
- Community mental health centers
- School-based centers
- Indian health and tribal 638 facilities
- Ambulatory surgical or treatment centers
- Residential treatment centers
- Home health agencies
- Diagnostic lab or imaging centers
- Rehabilitation or other therapeutic health settings
- Eligible recipients' residences⁴⁷

Several other states, including Minnesota and Kansas, provide Medicaid coverage for telehealth services in the home, or "telehome" care.⁴⁸ Again, if the focus is on the service provided, the location of the provider or patient should not matter.

Written when the TDA was first placed into law, this restriction was a precaution to appease lawmakers wary of telemedicine's safety. Today, with nearly two decades of experience in a variety of telehealth technologies, the additional patient consent requirement is redundant, inefficient, and burdensome. If an informed consent requirement does not exist for in-person services, it should not be required for telehealth services. Informed consent would still be required when providing services via telehealth if that same service requires informed consent when delivered in person.

Recommendation 4

Remove the requirement necessitating an additional informed consent waiver be obtained prior to any telehealth service being rendered.

Rationale

Current California law requires a provider to obtain a signed patient consent form prior to any delivery of telemedicine health care services, regardless of the service being rendered.⁴⁹ This separate informed consent is solely applied to services provided using telemedicine, and is not related to any privacy, security or health services informed consent law on the state or federal level. Medicare does not impose this requirement.

III. Incorporate Telehealth into State Workforce Law

State workforce policies are important levers for increasing telehealth use in California. Professional licensure and scope-of-practice laws define what services health care professionals can provide. How California trains its health care workforce in its universities, and community-training programs shapes how care is provided, both now and in the future. While the TDA did not specifically address these issues, clarifications and modifications to existing workforce laws would enable the state to more fully realize the promise of telehealth technologies.

The Work Group considered statutory provisions to change state-based professional licensure, scope of practice, training, and loan repayment programs. The Work Group deferred discussions of licensure issues related to telehealth to the Federation of State Medical Boards. The Federation is exploring approaches to facilitating telehealth-delivered services across states. This section outlines recommendations for policy changes governing pilot programs to test scope-of-practice changes, a state-funded training program, and state-administered loan repayment programs. These programs are administered by the Office of Statewide Health Planning and Development (OSHPD), a department of the California Health and Human Services Agency.

Recommendation 5

Require Office of Statewide Health Planning and Development (OSHPD) to develop and implement a plan to provide greater visibility for the State Health Workforce Pilot Project (HWPP), and require that OSHPD prioritize HWPP projects that utilize telehealth.

Rationale

The increasing availability of telehealth technologies allows less-trained health care personnel to deliver health care services, with the support of more highly trained health personnel, in separate locations. This offers opportunities to expand timelier, and often higher quality, health care services to all Californians. While technology, and California's statutory and legal construct, extend the reach of personnel such as physicians and dentists, state scope of practice laws for allied health professionals limit the possibilities of telehealth.

Established in 1972, the State Health Workforce Pilot Project (HWPP) permits the safe and supervised testing of new staffing approaches to delivering health care, to inform the Legislature about promising scope of practice changes.⁵⁰ Without the program, it was difficult if not impossible to test a new approach without violating the practice act. Also, it appeared that numerous entities were trying new approaches but their efforts were not coordinated. State officials saw that a great deal of local resources were being wasted on small projects, with limited experimental value. By designing a statewide process to consider waivers and experimentation on a larger scale, scope of practice changes could be more efficiently and safely tested.

California is the only state in the nation to have such a mechanism. Given its past successes, the promise of new technologies to support new models of health care delivery, and the availability of new federal funding for health IT workforce pilot programs, the Legislature should revitalize HWPP. In HWPP's history, 75 of the more than 100 successfully completed projects have led to changes in scope of practice law, policy or regulation.⁵¹ Over the last 10 years, however, the program has been comparatively inactive, and many legislators are unaware of its existence.⁵²

Revitalizing HWPP could not come at a better time. ACA has made federal funds available for new models of primary care, which will expand access to Americans underserved by current health care systems.

For example, federal funds will be available for expanding the use of alternative health care providers to operate community health centers in medically underserved areas. U.S. Health and Human Services Secretary Kathleen Sebelius recently announced the release of \$15 million for the operation of nurse-managed health clinics. Such centers provide comprehensive primary care services to medically underserved communities.⁵³ However, according to the Nurse Practice Act in California, nurses must work in collaboration with physicians and have a written “standardized procedure” document on file detailing any practice restrictions or limitations required by the physician.⁵⁴ Through HWPP, pilot programs could be conducted to assess training needs and test the effectiveness of telehealth-aided collaboration models. Nurse-run clinics could be equipped with telehealth technologies that support more complex primary care cases than community clinics currently handle, and would have access to currently unavailable specialty care. HWPP provides a powerful vehicle for California to test and adapt different models, using telehealth technologies to meet some of California’s most pressing access and efficiency needs.

Other States’ Policies

Colorado, New Mexico, and Alaska have been experimenting with telehealth to expand scopes of practice for allied health professionals. Colorado expanded nurse practitioner scope of practice to allow larger caseloads of chronic heart failure patients, using at-home telehealth tools for vital sign monitoring, video visits, and patient education.⁵⁵

New Mexico is training community health workers, supervised via telehealth technologies by University of New Mexico medical specialists, to increase access to services for communicable and chronic diseases in remote areas of the state. The state also established a new process to review scopes of practice for health care professionals, recognizing that advances in technology and changes in citizen demand for health care make many proposed changes necessary and beneficial.⁵⁶

The Alaska Community Health Aide Program addresses the oral health needs of Alaska Natives in rural settings with a Dental Health Aide Program. The program provides a University of Washington primary care curriculum, which emphasizes community-level dental disease prevention. The curriculum incorporates innovative public health preventive and clinical strategies, including telehealth.⁵⁷

Recommendation 6

Require OSHPD to receive assurances that each program receiving Song-Brown funds includes training on uses of telehealth to expand access to, and increase the efficiency of, needed care; and train prospective health professionals in the use of telehealth technologies, to the greatest extent possible.

Rationale

The state Song-Brown Program provides more than \$7 million annually to primary care training programs in areas of California with poor access to health care, providing residents and students with experience in increasing access to medically underserved communities. The Song-Brown Health Care Workforce Training Act was passed by the California Legislature in 1973 to encourage program graduates to practice in designated underserved areas of California. Named for the co-authors of the Act, then-Assemblymember Willie Brown and then-Senator Alfred H. Song, it has expanded the training programs of family practice residents and primary care physician assistants. Later amendments added funding for osteopathic family physician and family nurse practitioner programs.⁵⁸

The program has a large impact on primary care training in California. It funds 27 of the state’s 38 family practice residency training programs; seven of the 22 family nurse practitioner programs; six of 10 physician assistant programs; and 34 of the 134 registered nurse programs in California.⁵⁹ Song-Brown is an excellent vehicle to promote the use of telehealth in addressing access barriers.

Recent national assessments of primary care training programs found that they often fail to give trainees experience using the equipment and care models that are needed to succeed in today's primary care practice settings.⁶⁰ Telehealth technologies make co-management among specialists, primary care providers and patients themselves possible. Use of these technologies decreases providers' feeling of isolation and disconnection from mainstream medicine when caring for underserved populations.⁶¹ Trainees often cite provider isolation and the lack of medical support, compared to academic medical institutions, as reasons for their deciding not to practice with underserved populations. Thus, including these technologies in training programs is important, to show trainees how primary care functions can be more effectively supported, through the use of technology.

OSHPD should consider giving higher priority for funding to primary care programs that partner with specialty training programs using telehealth technologies, to help address access needs in specialty areas experiencing the greatest unmet need (e.g., neurology, endocrinology, and dermatology).⁶²

Recommendation 7

Require OSHPD to incorporate mechanisms into loan repayment programs that assure telehealth technologies are being used to expand access to health care to underserved Californians. Certification criteria for approved sites and selection criteria for applicants should reflect the state's desire to maximize the use of telehealth technologies to the benefit of Californians with difficulty obtaining health care.

Rationale

The State of California, with support of federal matching funds, operates loan repayment programs for health professionals⁶³ who agree to a two- to four-year post-training service commitment in medically underserved areas. The programs receive \$1 million per year in federal funds, but in September 2010 received an additional \$2 million under the

American Recovery and Reinvestment Act of 2009. The state currently requires that sites hosting health professionals offer a "comprehensive system of care."⁶⁴ To be considered comprehensive, sites should be encouraged to implement telehealth to the greatest extent possible, to help support providers in expanding health care services into underserved areas.

California continues to experience a shortage in PCPs, and long wait times for specialists, especially among rural residents, the uninsured, and Medi-Cal beneficiaries^{65,66} State and federal loan repayment programs have been in use since the early 1970s, to help attract newly trained providers to where they are most needed. As described in the prior recommendation, health personnel shortages and distribution problems require actions that will support professionals in settings with limited resources. Given the promise of telehealth for forming virtual multidisciplinary teams and providing access to vast resources for consults and other services, California should use its loan repayment programs to encourage the use of telehealth.

By assuring that sites and providers are equipped and trained to use telehealth, the loan program would increase the likelihood that providers stay in underserved areas beyond the repayment period and specialists continue to partner with clinicians serving the underserved. Telehealth programs have been found to reduce the sense of isolation and improve professional satisfaction among community health providers. Such programs are being seen as key to retaining health care providers in isolated and resource-poor areas.⁶⁷

IV. Other Statutory Recommendations

Two additional Model Statute recommendations are proposed that are not found in current law. The first relates to the need for interoperability of telehealth equipment and software, so that data can be readily exchanged among telehealth devices, as well as with electronic health records (EHRs). The second would require the California Public Employees' Retirement System (CalPERS) to provide educational information to its enrollees about telehealth.

Recommendation 8

Require telehealth equipment and software vendors who seek to contract with the State of California to show that their products comply with current telehealth industry interoperability standards.

Rationale

As the use of technology in health care, epitomized by the drive towards implementation of EHRs and health information exchanges, becomes more pervasive, the need for that technology to be interoperable is crucial.

Different systems and equipment must be able to communicate with each other on several levels. Hardware or equipment interoperability allows one piece of machinery to transmit data to another; software interoperability permits access in two or more different operating systems. California, as a prudent steward of public funds, should ensure that all telehealth equipment purchased by state entities be interoperable. The state should require that any vendor who wishes to contract with California be able to show that their telehealth products comply with industry interoperability standards.

California has a history of working towards interoperability of systems. In 2002, the California Public Safety Communication Act included language defining the statute as one that “*strives for interoperability of a statewide integrated public safety communication system.*”⁶⁸ As with the interoperability of its public safety communication system, California needs to ensure that as it implements health care reform, all parts of the health care delivery system will be able to interact. The results will reduce costs and avoid waste of valuable and scarce state resources.

The telehealth industry in general complies with industry standards. There are a few vendors however, that develop and market products that are “proprietary” and unable to communicate/exchange data with similar units manufactured by competing vendors. Technology is also ever changing, as new discoveries are made, and products created. It is important that vendors adhere to industry standards and not market propriety equipment. Recognizing these hurdles, the Work Group acknowledged the difficulty in achieving complete interoperability, but members also recognized its importance as well. With a purchaser as large as the State of California insisting on proof of interoperability prior to purchase, the marketplace may increase efforts to reach that goal.

Recommendation 9

Require CalPERS to include telehealth services information in health benefits collateral materials for all beneficiaries.

Rationale

Californians overall are unfamiliar with telehealth, and the benefits it can offer. For example, telehealth services can help a patient avoid travel time to visit a specialist, or schedule an appointment at an earlier or more convenient time due to a greater choice of accessible doctors.

As the largest purchaser of health care services in the state, CalPERS should include information on telehealth services in its enrollment and benefits materials. By doing so, CalPERS will serve as a model to other health coverage programs in educating their members.

While a broad-based statewide telehealth education effort would be ideal, such a project may not be feasible in the current fiscal climate. However, in addition to the CalPERS distribution, the state also could consider using federal grants for telehealth education. For example, a \$3.4 million federal consumer assistance grant awarded to California in 2010⁶⁹ will go to the Department of Managed Health Care, which is partnering with the California Office of the Patient Advocate to help consumers navigate their health care coverage.⁷⁰ If permissible, such funds should also be used to educate consumers on telehealth.

V. Other Policy Recommendations

This section includes four policy recommendations that are not proposed for the Model Statute, but would accelerate uptake of telehealth services. These recommendations may be implemented through separate statutes or regulations, or through the marketplace.

Recommendation 1

Require the Legislative Analyst's Office to conduct a study to identify the most promising practices using telehealth-delivered care that could benefit Medi-Cal and other state-financed health programs.

Rationale

Commercial payers and Medicare have demonstrated innovative approaches in using telehealth technologies to create new models of care. These programs have provided ample evidence to support the Institute of Medicine's aims for the nation's health care delivery system—that it be safe, timely, efficient, equitable, effective, and patient-centered. An analysis by the California Legislative Analyst's Office (LAO) for legislative and executive branch leadership could identify priorities for Medi-Cal with respect to technologies, populations, and geographies. Such a report could lay the groundwork for the California Department of Health Care Services to plan for a strategic deployment of telehealth services statewide.

Recommendation 2

Require state activities related to Health Information Technology/Health Information Exchange (HIT/HIE) to explicitly include telehealth advocate representation.

Rationale

California's eHealth landscape currently has a broad spectrum of planning and infrastructure programs taking place in state and other public/non-profit sectors. The California Health and Human Services agency notes on its website that:

Achieving electronic health information exchange (HIE) through the application of health information technology (HIT) is one of the cornerstones of the overall healthcare reform strategy in California. Effective application of HIT and the implementation of interoperable HIE are key strategies to achieve the goals of better health care outcomes, efficiencies in the delivery of healthcare, and strengthening our emergency and disaster response preparedness.

The California Health and Human Services Agency (CHHS) serves as the lead agency on HIE and HIT issues for the State. CHHS works with the State Chief Information Officer (OCIO), the Department of Managed Health Care, the Business, Transportation and Housing Agency and others to oversee the State's HIE and HIT related efforts.⁷¹

Given the integral role telehealth can play in the state's health care delivery system—which is becoming increasingly reliant on technology, and will see a huge influx of patients under health reform—planning and infrastructure programs should explicitly include telehealth considerations in all appropriate areas. The Secretary of CHHS and other program leaders should include telehealth in their eHealth goals, and ensure that telehealth representatives play meaningful roles in eHealth project activities.

Recommendation 3

Require practitioners providing volunteer health services via telehealth to be included in any legislation that allows for malpractice coverage to volunteers providing health services.

Rationale

In 2010, Senator Ellen Corbett, (D-San Leandro), authored SB 1031, which would have created the Volunteer Insured Physicians Program. The program, which would have been administered by the California Medical Board, would have provided malpractice coverage to volunteer physicians for uncompensated care to patients in qualified health care entities. SB 1031 failed to pass out of committee during the legislative session.

Allowing retired practitioners to volunteer their time from clinics or from home, using telehealth technologies, could help alleviate the workforce dilemmas discussed in this report's Introduction and Workforce sections. However, when practitioners retire, they typically allow their malpractice insurance to lapse. Even if a practitioner has coverage, it may be an additional expense to extend that coverage to volunteer activities.

Current California law only provides malpractice protection for volunteer physicians who render care in specific situations, such as emergency care at a college or high school athletic event.^{72,73} Additionally, there is no specific protection for those physicians who provide volunteer services via telehealth. A program like the one proposed by SB 1031 could be an incentive for physicians to volunteer their services.

SB 1031 only covered services offered by a primary care physician. Telehealth is uniquely positioned to offer access to specialty services and other types of health care professionals. Should a bill like SB 1031 be introduced in a future legislative session, malpractice coverage for all telehealth practitioners, including physicians, advanced practice registered nurses, dentists, and optometrists should be included.

Other States' Policies

Many states provide charitable immunity protection and/or malpractice insurance programs for volunteer physicians. As of early 2009, 43 states had some form of protection for volunteer physicians in non-emergency circumstances, such as non-profit organizations, free clinics, government entities, etc.⁷⁴

Recommendation 4

Require malpractice insurance vendors and professional societies to educate practitioners regarding their options for malpractice coverage for telehealth services.

Rationale

Malpractice coverage is available through commercial carriers for services provided via telehealth. However, CCHP research and anecdotal evidence points to a disconnect between what providers think they can have covered, and what malpractice insurers understand telehealth services to be.

Work Group members provided valuable insights from their own experiences with their respective carriers. Some members noted that they had to explain to their carriers what telehealth was, but were readily able to obtain coverage. The fact that carriers needed to be educated on the specifics of telehealth is an indicator of its under-utilization. Further, the fact that providers were uncertain about their ability to obtain coverage indicates a need for education on both sides. By requiring malpractice insurance vendors to inform practitioners of their options, providers would be educated and the insurance vendors would need to become educated on what they will be offering in their coverage.

VI. Conclusion

California established early national leadership in telehealth policy, with passage of the Telemedicine Development Act of 1996. In the ensuing years, little has changed in state law. Major developments in technology, broadband availability, and health care applications have expanded the potential of telehealth to assist with California's current health care challenges. With the passage of national health care reform—and the commensurate increase in public and private coverage—California has an exciting opportunity to again become a national leader in telehealth policy.

By extending the reach of health care providers, telehealth can help to increase access to health care for all Californians, improve quality of care, make the health care delivery system work more efficiently, and provide opportunities for greater self-management for patients.

For telehealth to reach its full potential as an integral part of our state's health care system, current law needs to be updated, and new statutes and regulations put into place. Restrictions deemed useful and prudent in 1996 are no longer necessary today. With more than a decade's worth of experience and data showing that telehealth is both safe and effective, it is time for the removal of all barriers to its adoption and use.

The recommendations in this report will help California achieve these goals, and once again take a leadership role and serve as a model for the nation.

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72. California Business and Professions Code Sections 2395, 2395.5, 398.
73. California Government Code Section 8659
74. Orłowski, Anna. Medical Board of California. *Report to Address Assembly Bill 2342*, (December 31, 2008).

Appendix A: Telehealth Model Statute Work Group Charter

Purpose Of Work Group:

Specify/define statutory components (and rationale) for inclusion in a California Telehealth “Model Statute” that supports the integration of telehealth as a tool to improve population health and reshape the health care delivery system into a safe, timely, efficient, equitable, effective, and patient-centered system. The Work Group members’ task is to identify those concepts that would comprise a Model Statute for California.

Policy Goals

The Work Group identified three policy goals to guide the discussions:

- I. To create parity of telehealth among all health care delivery modes;
- II. To actively promote telehealth as a tool to advance stakeholders’ goals re: health status and health system improvement;
- III. To create opportunities and flexibility for telehealth to be used in new models of care and system innovation.

Key Considerations

Work Group members identified the following considerations as key to the work:

1. Allow for flexibility as technologies/processes/care and payment systems change over time;
2. Encourage diffusion of appropriate use of innovative technologies;
3. Consider policies related to reimbursement, workforce, facility and professional licensure, security and privacy, and the telecommunications industry;
4. Create a long-term vision, but be mindful of California’s economic/fiscal climate;
5. Maintain a consumer focus, with particular attention to the needs of underserved and populations with special health care needs;
6. Ensure that only policies appropriate for a statute are included, versus policies best placed in regulations or contracts.

Appendix B:

Telehealth Model Statute Language

All new proposed language is italicized. However, some proposals are contained in a larger section that has been changed. In such cases, the relevant language to a specific proposal has been italicized and bolded. Additionally, some proposals will require changes in more than one section of the California Code. Therefore, some sections will be repeated under different proposals or contain very similar, if not exactly the same language.

An act to repeal and add Section 2290.5 of the Business and Professions Code; to amend Sections 22863 and 22953 of the Government Code; to repeal and add Sections 1374.13, 127934, 128196, and to amend Sections 127926, 128025, 128035, 128125, 128551, 128160, and 128225 of, the Health and Safety Code; to repeal and add Section 10123.85 of the Insurance Code; to add Section 12114 of the Public Contract Code; to repeal and add Section 14132.72, and repeal Section 14132.725, of the Welfare and Institutions Code, and to change references from “telemedicine” to “telehealth” in the California Codes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Lack of primary care, specialty providers, and transportation continue to be significant barriers to access to health services in medically underserved rural and urban areas.

(b) Parts of California have difficulty attracting and retaining health professionals, as well as supporting local health facilities to provide a continuum of health care.

(c) Many health care providers in medically underserved areas are isolated from mentors, colleagues, and the information resources necessary to support them personally and professionally.

(d) It is the intent of the Legislature to create a parity of telehealth with other health care delivery modes; to actively promote telehealth as a tool to advance stakeholders’ goals regarding health status and health system improvement and to create opportunities and flexibility for telehealth to be used in new models of care and system improvements.

(e) Telehealth means the mode of delivering health care services and public health utilizing information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from healthcare providers.

(f) Telehealth is part of a multifaceted approach to address the problem of inadequate provider distribution and the development of health systems in medically underserved areas by improving communication capabilities and providing convenient access to up-to-date information, consultations, and other forms of support.

(g) The use of information and telecommunication technologies to deliver health services has the potential to reduce costs, improve quality, change the conditions of practice, and improve access to health care, particularly in rural and other medically underserved areas.

(h) Telehealth will assist in maintaining or improving the physical and economic health of medically underserved communities by keeping the source of medical care in the local area, strengthening the health infrastructure, and preserving health care-related jobs.

(i) Consumers of health care will benefit from telehealth in many ways, including expanded access to providers, faster and more convenient treatment, better continuity of care, reduction of lost work time and travel costs, and the ability to remain with support networks.

(j) It is the intent of the Legislature that the fundamental health care provider-patient relationship can not only be preserved, but also augmented and enhanced, through the use of telehealth as a tool to be integrated into practices.

(k) Without the assurance of payment and the resolution of legal and policy barriers, the full potential of telehealth will not be realized.

(l) This act shall be known as the "Telehealth Advancement Act of 2011."

SEC 2. Section 2290.5 of the Business and Professions Code is repealed.

2290.5. (a) (1) For the purposes of this section, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of this section.

(2) For purposes of this section, "interactive" means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.

(b) For the purposes of this section, "health care practitioner" has the same meaning as "licentiate" as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000):

(c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient's legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient's legal representative verbally and in writing:

(1) The patient or the patient's legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient's legal representative would otherwise be entitled.

(2) A description of the potential risks, consequences, and benefits of telemedicine.

(3) All existing confidentiality protections apply.

(4) All existing laws regarding patient access to medical information and copies of medical records apply.

(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.

(d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

REDEFINE TELEMEDICINE AS TELEHEALTH AND REMOVE EXISTING RESTRICTIONS

1A. Update the term “telemedicine” used in current law to “telehealth” to reflect changes in technologies, settings, and applications, both for medical and other purposes.

SEC. 3. Section 2290.5 is added to the Business and Professions Code, to read:

2290.5. Definition of Telehealth.

(a)(1) For the purposes of this section, “telehealth” means a mode of delivering health care services and public health that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(2) For the purposes of this section, “health care provider” means any person who is licensed under Division 2, Healing Arts, of the Business and Professions Code.

(3) For the purposes of this section, “asynchronous store and forward” transfer means the transmission of a patient’s medical information from an originating site to the provider at the distant site without the patient being present.

(4) For the purposes of this section, “distant site” means the site at which the health care provider delivering the service is located at the time the service is provided via a telecommunications system.

(5) For the purposes of this section, “originating site” means the location of the patient at the time the service is furnished via a telecommunications where the asynchronous store and forward transfer occurs.

(b) This section shall not be construed to alter the scope of practice of any health care provider.

(c) All laws regarding the confidentiality of health care information and the patient’s rights to their medical information shall apply to telehealth interactions.

1B. Include the asynchronous application of technologies in the definition of telehealth and remove the 2013 sunset date for Medi-Cal reimbursement of teledermatology, teleophthalmology, teleoptometry services.

SEC. 3. Section 2290.5 is added to the Business and Professions Code, to read:

2290.5. Definition of Telehealth.

(a)(1) For the purposes of this section, “telehealth” means a mode of delivering health care services and public health that utilizes information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health providers. Telehealth allows services to be accessed when providers are in a distant site and patients are in the originating site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(2) For the purposes of this section, “health care provider” means any person who is licensed under Division 2, Healing Arts, of the Business and Professions Code.

(3) For the purposes of this section, “asynchronous store and forward” transfer means the transmission of a patient’s medical information from an originating site to the provider at the distant site without the patient being present.

(4) For the purposes of this section, “distant site” means the site at which the health care provider delivering the service is located at the time the service is provided via a telecommunications system.

(5) For the purposes of this section, “originating site” means the location of the patient at the time the service being furnished via a telecommunications system occurs or the location from which the asynchronous store and forward transfer occurs.

(b) This section shall not be construed to alter the scope of practice of any health care provider.

(c) All laws regarding the confidentiality of health care information and the patient’s rights to their medical information shall apply to telehealth interactions.

SEC 22. Section 14132.725(e) and (f) of the Welfare and Institutions Code is repealed.

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, "teleophthalmology and teledermatology by store and forward" means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all-county letters, provider bulletins, and similar instructions.

(d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.

~~—(e) The health care provider shall comply with the informed consent provisions of subdivisions (c) to (g), inclusive, of, and subdivisions (i) and (j) of, Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology or teledermatology by store and forward.~~

~~—(f) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.~~

1C. Remove restrictions in current telemedicine definition that prohibit telehealth-delivered services provided via email and telephone.

SEC. 6. Section 1374.13 of the Health and Safety Code is repealed.

~~1374.13. (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.~~

~~(b) For the purposes of this section, the meaning of "telemedicine" is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.~~

~~(c) On and after January 1, 1997, no health care service plan contract that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the enrollee or subscriber and the plan. The requirement of this subdivision shall be operative for health care service plan contracts with the Medi-Cal managed care program only to the extent that both of the following apply:~~

~~(1) Telemedicine services are covered by, and reimbursed under, the Medi-Cal fee-for-service program, as provided in subdivision (c) of Section 14132.72.~~

~~(2) Medi-Cal contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.~~

~~(d) Health care service plans shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.~~

SEC. 7. Section 1374.13 of the Health and Safety Code is added to read:

1374.13. (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services provided, and every health care service plan shall adopt payment policies consistent with this Section to compensate health care providers who provide covered health care services through telehealth.*

(d) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(e) Health care service plans shall pay for covered health care services when provided by information and communication technologies, including, but not limited to, telephone or Internet technologies, and for asynchronous store and forward services.

(f) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the contract amount the health care service plan pays for the same service when provided in an in-person encounter with the patient.*

(g) *The health care service plan shall not limit the type of setting where services are provided for the patient or the provider and shall pay providers at both the distant site and the originating site.*

(h) *The requirements of this subdivision shall also be operative for health care service plan contracts with the Medi-Cal managed care program.*

SEC. 17. Section 10123.85 of the Insurance Code is repealed.

10123.85. (a) *It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.*

(b) *For the purposes of this section, the meaning of “telemedicine” is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *On and after January 1, 1997, no disability insurance contract that is issued, amended, or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the policyholder or contractholder and the insurer.*

(d) *Disability insurers shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.*

SEC. 18. Section 10123.85 of the Insurance Code is added to read:

10123.85. (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *No disability insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services provided, and every disability insurer shall adopt payment policies consistent with this Section to compensate health care providers who provide covered health care services through telehealth.*

(d) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(e) Disability insurers shall pay for covered health care services when provided by information and communication technologies, including, but not limited to, telephone or Internet technologies, and for asynchronous store and forward services.

(f) Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the contract amount the disability insurer pays for the same service when provided in an in-person encounter with the patient.

(g) The disability insurer shall not limit the type of setting where services are provided for the patient or the provider and shall pay the providers at both the distant site and the originating site.

(h) Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.

SEC. 20. Section 14132.72 of the Welfare & Institutions Code is repealed.

14132.72. (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, "telemedicine" and "interactive" are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code:

(c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.

(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits:

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

SEC. 21. Section 14132.72 of the Welfare & Institutions Code is added to read:

14132.72 (a) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.

(b) For the purposes of this section, "telehealth", "health care provider", "asynchronous store and forward", "distant site", and "originating site" have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is provided by telehealth, including, but not limited to, services provided via telephone or Internet technologies and services provided by asynchronous store and forward transfer.

(d) The Department shall not require any provider to document a barrier to an in-person visit for coverage of services provided via telehealth

(e) Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the fee schedule amount the program pays for the same service when provided in an in-person encounter with the patient.

(f) The Department shall not limit the type of setting where services are provided for the patient or the provider when paying the providers at both the distant site and the originating site.

(g) Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.

(h) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part I of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.

2A. Specify that any service otherwise covered under standard contract terms (e.g., covered benefit, medically necessary) must be covered, whether provided in-person or via telehealth.

SEC. 6. Section 1374.13 of the Health and Safety Code is repealed.

1374.13. (a) It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.

(b) For the purposes of this section, the meaning of “telemedicine” is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) On and after January 1, 1997, no health care service plan contract that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the enrollee or subscriber and the plan. The requirement of this subdivision shall be operative for health care service plan contracts with the Medi-Cal managed care program only to the extent that both of the following apply:

(1) Telemedicine services are covered by, and reimbursed under, the Medi-Cal fee-for-service program, as provided in subdivision (c) of Section 14132.72.

(2) Medi-Cal contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.

(d) Health care service plans shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

SEC. 7. Section 1374.13 of the Health and Safety Code is added to read:

1374.13. (a) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.

(b) For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services provided, and every health care service plan shall adopt payment policies consistent with this Section to compensate health care providers who provide covered health care services through telehealth.

(d) Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.

(e) Health care service plans shall pay for covered health care services when provided by information and communication technologies, including, but not limited to, telephone or Internet technologies, and for asynchronous store and forward services.

(f) Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the contract amount the health care service plan pays for the same service when provided in an in-person encounter with the patient.

(g) *The health care service plan shall not limit the type of setting where services are provided for the patient or the provider and shall pay providers at both the distant site and the originating site.*

(h) *The requirements of this subdivision shall also be operative for health care service plan contracts with the Medi-Cal managed care program.*

SEC. 17. Section 10123.85 of the Insurance Code is repealed.

10123.85. (a) *It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.*

(b) *For the purposes of this section, the meaning of “telemedicine” is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *On and after January 1, 1997, no disability insurance contract that is issued, amended, or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the policyholder or contractholder and the insurer.*

(d) *Disability insurers shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.*

SEC. 18. Section 10123.85 of the Insurance Code is added to read:

10123.85. (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) ***No disability insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services provided, and every disability insurer shall adopt payment policies consistent with this Section to compensate health care providers who provide covered health care services through telehealth.***

(d) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(e) *Disability insurers shall pay for covered health care services when provided by information and communication technologies, including, but not limited to, telephone or Internet technologies, and for asynchronous store and forward services.*

(f) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the contract amount the disability insurer pays for the same service when provided in an in-person encounter with the patient.*

(g) *The disability insurer shall not limit the type of setting where services are provided for the patient or the provider and shall pay the providers at both the distant site and the originating site.*

(h) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

SEC. 20. Section 14132.72 of the Welfare & Institutions Code is repealed.

14132.72. (a) *It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.*

(b) *For the purposes of this section, “telemedicine” and “interactive” are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) (1) *Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to*

reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.

(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits.

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

SEC. 21. Section 14132.72 of the Welfare & Institutions Code is added to read:

14132.72 (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is provided by telehealth, including, but not limited to, services provided via telephone or Internet technologies and services provided by asynchronous store and forward transfer.*

(d) *The Department shall not require any provider to document a barrier to an in-person visit for coverage of services provided via telehealth*

(e) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the fee schedule amount the program pays for the same service when provided in an in-person encounter with the patient.*

(f) *The Department shall not limit the type of setting where services are provided for the patient or the provider when paying the providers at both the distant site and the originating site.*

(g) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(h) *Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part I of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.*

2B. Eliminate the current Medi-Cal requirement to document a barrier to an in-person visit for coverage of services provided using telehealth.

SEC. 20. Section 14132.72 of the Welfare & Institutions Code is repealed.

14132.72. (a) *It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.*

(b) *For the purposes of this section, “telemedicine” and “interactive” are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.

(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits.

(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.

SEC. 21. Section 14132.72 of the Welfare & Institutions Code is added to read:

14132.72 (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, "telehealth", "health care provider", "asynchronous store and forward", "distant site", and "originating site" have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is provided by telehealth, including, but not limited to, services provided via telephone or Internet technologies and services provided by asynchronous store and forward transfer.*

(d) *The Department shall not require any provider to document a barrier to an in-person visit for coverage of services provided via telehealth.*

(e) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the fee schedule amount the program pays for the same service when provided in an in-person encounter with the patient.*

(f) *The Department shall not limit the type of setting where services are provided for the patient or provider when paying the providers at both the distant site and the originating site.*

(g) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(h) *Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part I of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.*

3. Require private health care payers and Medi-Cal to cover encounters between licensed health practitioners and enrollees irrespective of the setting of the enrollee and provider(s).

SEC. 6. Section 1374.13 of the Health and Safety Code is repealed.

1374.13. (a) *It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.*

(b) For the purposes of this section, the meaning of “telemedicine” is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) On and after January 1, 1997, no health care service plan contract that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the enrollee or subscriber and the plan. The requirement of this subdivision shall be operative for health care service plan contracts with the Medi-Cal managed care program only to the extent that both of the following apply:

(1) Telemedicine services are covered by, and reimbursed under, the Medi-Cal fee-for-service program, as provided in subdivision (c) of Section 14132.72.

(2) Medi-Cal contracts with health care service plans are amended to add coverage of telemedicine services and make any appropriate capitation rate adjustments.

(d) Health care service plans shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

SEC. 7. Section 1374.13 of the Health and Safety Code is added to read:

1374.13. (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *No health care service plan shall require that in-person contact occur between a health care provider and a patient before payment is made for the covered services provided, and every health care service plan shall adopt payment policies consistent with this Section to compensate health care providers who provide covered health care services through telehealth.*

(d) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(e) *Health care service plans shall pay for covered health care services when provided by information and communication technologies, including, but not limited to, telephone or Internet technologies, and for asynchronous store and forward services.*

(f) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the contract amount the health care service plan pays for the same service when provided in an in-person encounter with the patient.*

(g) *The health care service plan shall not limit the type of setting where services are provided for the patient or the provider and shall pay providers at both the distant site and the originating site.*

(h) *The requirements of this subdivision shall also be operative for health care service plan contracts with the Medi-Cal managed care program.*

SEC. 17. Section 10123.85 of the Insurance Code is repealed.

10123.85. (a) *It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.*

(b) For the purposes of this section, the meaning of “telemedicine” is as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.

(c) On and after January 1, 1997, no disability insurance contract that is issued, amended, or renewed for hospital, medical, or surgical coverage shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine, subject to all terms and conditions of the contract agreed upon between the policyholder or contractholder and the insurer.

(d) Disability insurers shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.

SEC. 18. Section 10123.85 of the Insurance Code is added to read:

10123.85. (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *No disability insurer shall require that in-person contact occur between a health care provider and a patient before payment is made for the services provided, and every disability insurer shall adopt payment policies consistent with this Section to compensate health care providers who provide covered health care services through telehealth.*

(d) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(e) *Disability insurers shall pay for covered health care services when provided by information and communication technologies, including, but not limited to, telephone or Internet technologies, and for asynchronous store and forward services.*

(f) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the contract amount the disability insurer pays for the same service when provided in an in-person encounter with the patient.*

(g) *The disability insurer shall not limit the type of setting where services are provided for the patient or the provider and shall pay the providers at both the distant site and the originating site.*

(h) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

SEC. 20. Section 14132.72 of the Welfare & Institutions Code is repealed.

14132.72. (a) ~~It is the intent of the Legislature to recognize the practice of telemedicine as a legitimate means by which an individual may receive medical services from a health care provider without person-to-person contact with the provider.~~

~~(b) For the purposes of this section, “telemedicine” and “interactive” are defined as those terms are defined in subdivision (a) of Section 2290.5 of the Business and Professions Code:~~

~~(c) (1) Commencing July 1, 1997, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, subject to reimbursement policies developed by the Medi-Cal program to compensate licensed health care providers who provide health care services, that are otherwise covered by the Medi-Cal program, through telemedicine. The audio and visual telemedicine system used shall, at a minimum, have the capability of meeting the procedural definition of the Current Procedural Terminology Fourth Edition (CPT-4) codes which represent the service provided through telemedicine. The telecommunications equipment shall be of a level of quality to adequately complete all necessary components to document the level of service for the CPT-4 code billed. If a peripheral diagnostic scope is required to assess the patient, it shall provide adequate resolution or audio quality for decisionmaking.~~

~~(2) The department shall report to the appropriate committees of the Legislature, by January 1, 2000, on the application of telemedicine to provide home health care; emergency care; critical and intensive care, including neonatal care; psychiatric evaluation; psychotherapy; and medical management as potential Medi-Cal benefits:~~

~~(d) The Medi-Cal program shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines.~~

~~(e) The Medi-Cal program shall pursue private or federal funding to conduct an evaluation of the cost-effectiveness and quality of health care provided through telemedicine by those providers who are reimbursed for telemedicine services by the program.~~

SEC. 21. Section 14132.72 of the Welfare & Institutions Code is added to read:

14132.72 (a) *It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider.*

(b) *For the purposes of this section, “telehealth”, “health care provider”, “asynchronous store and forward”, “distant site”, and “originating site” have the meanings as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code.*

(c) *In-person contact between a health care provider and a patient shall not be required under the Medi-Cal program for any service otherwise covered by the Medi-Cal program when the service is provided by telehealth, including, but not limited to, services provided via telephone or Internet technologies and services provided by asynchronous store and forward transfer.*

(d) *The Department shall not require any provider to document a barrier to an in-person visit for coverage of services provided via telehealth*

(e) *Payment for covered services provided by telehealth shall be the lower of the usual and customary rate charged for that service or the fee schedule amount the program pays for the same service when provided in an in-person encounter with the patient.*

(f) *The Department shall not limit the type of setting where services are provided for the patient or the provider when paying the providers at both the distant site and the originating site.*

(g) *Payment for telehealth interactions shall include reasonable compensation to the originating site for the transmission cost incurred during the delivery of health care services.*

(i) *Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part I of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.*

4. Remove the requirement necessitating an additional informed consent waiver be obtained prior to any telehealth service being rendered.

SEC 2. Section 2290.5 of the Business and Professions Code is repealed.

~~2290.5. (a) (1) For the purposes of this section, “telemedicine” means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes “telemedicine” for purposes of this section.~~

~~(2) For purposes of this section, “interactive” means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.~~

~~(b) For the purposes of this section, “health care practitioner” has the same meaning as “licentiate” as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000).~~

~~(c) Prior to the delivery of health care via telemedicine, the health care practitioner who has ultimate authority over the care or primary diagnosis of the patient shall obtain verbal and written informed consent from the patient or the patient’s legal representative. The informed consent procedure shall ensure that at least all of the following information is given to the patient or the patient’s legal representative verbally and in writing:~~

~~(1) The patient or the patient’s legal representative retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient or the patient’s legal representative would otherwise be entitled.~~

~~(2) A description of the potential risks, consequences, and benefits of telemedicine.~~

~~(3) All existing confidentiality protections apply.~~

~~(4) All existing laws regarding patient access to medical information and copies of medical records apply.~~

~~(5) Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.~~

(d) A patient or the patient's legal representative shall sign a written statement prior to the delivery of health care via telemedicine, indicating that the patient or the patient's legal representative understands the written information provided pursuant to subdivision (a), and that this information has been discussed with the health care practitioner, or his or her designee.

(e) The written consent statement signed by the patient or the patient's legal representative shall become part of the patient's medical record.

(f) The failure of a health care practitioner to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(g) All existing laws regarding surrogate decisionmaking shall apply. For purposes of this section, "surrogate decisionmaking" means any decision made in the practice of medicine by a parent or legal representative for a minor or an incapacitated or incompetent individual.

(h) Except as provided in paragraph (3) of subdivision (c), this section shall not apply when the patient is not directly involved in the telemedicine interaction, for example when one health care practitioner consults with another health care practitioner.

(i) This section shall not apply in an emergency situation in which a patient is unable to give informed consent and the representative of that patient is not available in a timely manner.

(j) This section shall not apply to a patient under the jurisdiction of the Department of Corrections or any other correctional facility.

(k) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

INCORPORATE TELEHEALTH INTO STATE WORKFORCE LAW

5. Require the Office of Statewide Planning and Development (OSHPD) to develop and implement a plan to provide greater visibility for the State Health Workforce Pilot Project (HWPP) and require that OSHPD prioritize HWPP projects that utilize telehealth.

SEC. 12. Section 128125 of the Health and Safety Code is amended to read:

128125. The Legislature finds that there is a need to improve the effectiveness of health care delivery systems. One way of accomplishing that objective is to utilize health care personnel in new roles and to reallocate health tasks to better meet the health needs of the citizenry.

The Legislature finds that experimentation with new kinds and combinations of health care delivery systems is desirable, and that, for purposes of this experimentation, a select number of publicly evaluated health workforce pilot projects should be exempt from the healing arts practices acts. The Legislature also finds that large sums of public and private funds are being spent to finance health workforce innovation projects, and that the activities of some of these projects exceed the limitations of state law. These projects may jeopardize the public safety and the careers of persons who are trained in them. It is the intent of the Legislature to establish the accountability of health workforce innovation projects to the requirements of the public health, safety, and welfare, and the career viability of persons trained in these programs. Further, it is the intent of this legislation that existing healing arts licensure laws incorporate innovations developed in approved projects that are likely to improve the effectiveness of health care delivery systems. ***Finally, the Legislature finds that the use of telehealth, as defined in Section 2290.5 of the Business and Professions Code, in the delivery of health care in California shall be supported and health workforce innovation projects incorporating telehealth shall receive priority.***

SEC. 13. Section 128160 of the Health and Safety Code is amended to read:

128160. (a) Pilot projects may be approved in the following fields:

- (1) Expanded role medical auxiliaries.
- (2) Expanded role nursing.
- (3) Expanded role dental auxiliaries.
- (4) Maternal child care personnel.

- (5) Pharmacy personnel.
 - (6) Mental health personnel.
 - (7) Other health care personnel including, but not limited to, veterinary personnel, chiropractic personnel, podiatric personnel, geriatric care personnel, therapy personnel, and health care technicians.
- (b) Projects that operate in rural and central city areas shall be given priority.
 - (c) **Projects that utilize telehealth to expand the reach of health care personnel to medically or dentally underserved populations in the State or to increase availability of care for all Californians shall be given priority.**

SEC. 14. Section 128196 of the Health and Safety Code is added to read:

128196. The Legislature finds and declares all of the following:

- (a) **To more effectively utilize health care personnel in new roles and to utilize new technologies, such as telehealth, as defined in Section 2290.5 of the Business and Professions Code, to better meet the health needs of the citizenry, the Office shall develop and implement a plan within six (6) months of the enactment of the Telehealth Advancement Act of 2011, to inform the Legislature and the health care community of the efforts of the Workforce Pilot Project related to telehealth.**
- (b) **The Office will provide an annual report to the Senate Health Committee and the Assembly Committee on Health to demonstrate increased efforts to implement the Workforce Pilot Project, including projects implementing telehealth.**
- (c) **The Office will complete evaluation of approved projects within ninety days of submission by the project sponsor and hold public hearings on the outcomes.**

6. Require OSHPD to receive assurances that each program receiving Song-Brown funds includes training on uses of telehealth to expand access to, and increase the efficiency of, needed care; and train prospective health professionals in the use of telehealth technologies, to the greatest extent possible.

SEC. 10. Section 128025 of the Health and Safety Code is amended to read:

128025. For the purpose of this article, “innovative programs of education in the health professions” means programs for the development of physicians and surgeons, podiatrists, dentists, pharmacists, nurses, optometrists, and occupations in the allied health professions, that emphasize all of the following:

- (a) The practice in the community on the part of graduates of the program.
- (b) The utilization of existing teaching resources and clinical care facilities within the community where the program is located.
- (c) The development of curricular mechanisms that allow for movement from one occupational category to the next, up to and including the doctor of medicine level.
- (d) The training of persons possessing previously acquired health care skills, for positions of greater responsibility, with an emphasis upon corpsmen honorably discharged from the military.
- (e) The training of persons with little or no formal education but with a willingness and aptitude to acquire health care skills.
- (f) The development of coordination with community health care facilities to insure quality education and satisfactory employment opportunities for graduates of the program; *and that*
- (g) **The training of persons in telehealth, as defined in Section 2290.5 of the Business and Professions Code, and utilization of telehealth technologies.**

SEC. 11 Section 128035 of the Health and Safety Code is amended to read:

128035. The office is authorized to make grants, from funds appropriated by the Legislature for this purpose, to assist organizations in meeting the cost of special projects to plan, develop, or establish innovative programs of education in the health professions, **such as programs in telehealth**, or for research in the various fields related to education in the health professions, or to develop training for new types of health professions personnel, or to meet the costs of planning experimental teaching facilities.

In determining priority of project applications, the office shall give the highest priority to:

- (1) Applicants able to obtain commitments for matching planning funds from other governmental and private sources.
- (2) Applicants who develop a preliminary plan that conforms to the criteria stated hereinabove for innovative programs of education in the health sciences.
- (3) Applicants that in its judgment are most able to translate a plan into a feasible program.

SEC.15. Section 128225 of the Health and Safety Code is amended to read:

128225. The commission shall do all of the following:

(a) Identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist.

(b) Establish standards for family practice training programs and family practice residency programs, postgraduate osteopathic medical programs in family practice, and primary care physician assistants programs and programs that train primary care nurse practitioners, including appropriate provisions to encourage family physicians, osteopathic family physicians, primary care physician's assistants, and primary care nurse practitioners who receive training in accordance with this article and Article 2 (commencing with Section 128250) to provide needed services in areas of unmet need within the state. Standards for family practice residency programs shall provide that all the residency programs contracted for pursuant to this article and Article 2 (commencing with Section 128250) shall both meet the Residency Review Committee on Family Practice's "Essentials" for Residency Training in Family Practice and be approved by the Residency Review Committee on Family Practice. Standards for postgraduate osteopathic medical programs in family practice, as approved by the American Osteopathic Association Committee on Postdoctoral Training for interns and residents, shall be established to meet the requirements of this subdivision in order to ensure that those programs are comparable to the other programs specified in this subdivision. Every program shall include a component of training designed for medically underserved multicultural communities, lower socioeconomic neighborhoods, or rural communities, and shall be organized to prepare program graduates for service in those neighborhoods and communities. ***Every program shall also include training on the current uses of telehealth, as defined in Section 2290.5 of the Business and Professions Code, and telehealth technologies to the greatest extent possible to expand access to and increase the delivery of care.*** Medical schools receiving funds under this article and Article 2 (commencing with Section 128250) shall have programs or departments that recognize family practice as a major independent specialty. Existence of a written agreement of affiliation or association between a hospital and an accredited medical school shall be regarded by the commission as a favorable factor in considering recommendations to the director for allocation of funds appropriated to the state medical contract program established under this article and Article 2 (commencing with Section 128250). For purposes of this subdivision, "family practice" includes the general practice of medicine by osteopathic physicians.

(c) Establish standards for registered nurse training programs. The commission may accept those standards established by the Board of Registered Nursing.

(d) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of family practice programs or departments and family practice residencies and programs for the training of primary care physician assistants and primary care nurse practitioners that are submitted to the Health Professions Development Program for participation in the contract program established by this article and Article 2 (commencing with Section 128250). If the commission determines that a program proposal that has been approved for funding or that is the recipient of funds under this article and Article 2 (commencing with Section 128250) does not meet the standards established by the commission, it shall submit to the Director of the Office of Statewide Health Planning and Development and the Legislature a report detailing its objections. The commission may request the Office of Statewide Health Planning and Development to make advance allocations for program development costs from amounts appropriated for the purposes of this article and Article 2 (commencing with Section 128250).

(e) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of registered nurse training programs that are submitted to the Health

Professions Development Program for participation in the contract program established by this article. If the commission determines that a program proposal that has been approved for funding or that is the recipient of funds under this article does not meet the standards established by the commission, it shall submit to the Director of the Office of Statewide Health Planning and Development and the Legislature a report detailing its objections. The commission may request the Office of Statewide Health Planning and Development to make advance allocations for program development costs from amounts appropriated for the purposes of this article.

(f) Establish contract criteria and single per-student and per-resident capitation formulas that shall determine the amounts to be transferred to institutions receiving contracts for the training of family practice students and residents and primary care physician's assistants and primary care nurse practitioners and registered nurses pursuant to this article and Article 2 (commencing with Section 128250), except as otherwise provided in subdivision (d). Institutions applying for or in receipt of contracts pursuant to this article and Article 2 (commencing with Section 128250) may appeal to the director for waiver of these single capitation formulas. The director may grant the waiver in exceptional cases upon a clear showing by the institution that a waiver is essential to the institution's ability to provide a program of a quality comparable to those provided by institutions that have not received waivers, taking into account the public interest in program cost-effectiveness. Recipients of funds appropriated by this article and Article 2 (commencing with Section 128250) shall, as a minimum, maintain the level of expenditure for family practice or primary care physician's assistant or family care nurse practitioner training that was provided by the recipients during the 1973-74 fiscal year. Recipients of funds appropriated for registered nurse training pursuant to this article shall, as a minimum, maintain the level of expenditure for registered nurse training that was provided by recipients during the 2004-05 fiscal year. Funds appropriated under this article and Article 2 (commencing with Section 128250) shall be used to develop new programs or to expand existing programs, and shall not replace funds supporting current family practice or registered nurse training programs. Institutions applying for or in receipt of contracts pursuant to this article and Article 2 (commencing with Section 128250) may appeal to the director for waiver of this maintenance of effort provision. The director may grant the waiver if he or she determines that there is reasonable and proper cause to grant the waiver.

(g) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of special programs that may be funded on other than a capitation rate basis. These special programs may include the development and funding of the training of primary health care teams of family practice residents or family physicians and primary care physician assistants or primary care nurse practitioners or registered nurses, undergraduate medical education programs in family practice, and programs that link training programs and medically underserved communities in California that appear likely to result in the location and retention of training program graduates in those communities. These special programs also may include the development phase of new family practice residency, primary care physician assistant programs, primary care nurse practitioner programs, or registered nurse programs. The commission shall establish standards and contract criteria for special programs recommended under this subdivision.

(h) Review and evaluate these programs regarding compliance with this article and Article 2 (commencing with Section 128250). One standard for evaluation shall be the number of recipients who, after completing the program, actually go on to serve in areas of unmet priority for primary care family physicians in California or registered nurses who go on to serve in areas of unmet priority for registered nurses.

(i) Review and make recommendations to the Director of the Office of Statewide Health Planning and Development on the awarding of funds for the purpose of making loan assumption payments for medical students who contractually agree to enter a primary care specialty and practice primary care medicine for a minimum of three consecutive years following completion of a primary care residency training program pursuant to Article 2 (commencing with Section 128250).

SEC. 16. Section 128551 of the Health and Safety Code is amended to read:

128551. (a) It is the intent of this article that the Health

Professions Education Foundation and the office provide the ongoing program management of the two programs identified in subdivision (b) of Section 128550 as a part of the California Physician Corps Program.

(b) For purposes of subdivision (a), the foundation shall consult with the Medical Board of California, Office of Statewide Planning and Development, and shall establish and consult with an advisory committee of not more than seven members, that shall include two members recommended by the California Medical Association and may include other members of the medical community, including ethnic representatives, medical schools, health advocates representing ethnic communities, *experts in telehealth, as defined in Section 2290.5 of the Business and Professions Code*, primary care clinics, public hospitals, and health systems, statewide agencies administering state and federally funded programs targeting underserved communities, and members of the public with expertise in health care issues.

7. Require OSHPD to incorporate mechanisms into loan repayment programs that assure that telehealth technologies are being used to expand access to health care to underserved Californians. Certification criteria for approved sites and selection criteria for applicants should reflect the state's desire to maximize the use of telehealth technologies to the benefit of Californians with difficulty obtaining health care.

SEC. 8. Section 127926 of the Health and Safety Code is amended to read:

127926. It is the intent of this article that the Office of Statewide Health Planning and Development, in consultation with the Dental Board of California, the Medical Board of California, the medical and dental community, including ethnic representatives, *experts in telehealth, as defined in Section 2290.5 of the Business and Professions Code*, medical and dental schools, health advocates representing ethnic communities, primary care clinics, public hospitals and health systems, statewide agencies administering state and federally funded programs targeting underserved communities, and members of the public with health care issue area expertise shall develop and implement the California Medical and Dental Student Loan Repayment Program of 2002.

SEC. 9. Section 127934 is added to the Health and Safety Code, to read:

127934. The office shall incorporate mechanisms into the Program to assure that telehealth technologies are being used to expand access to health care to the medically underserved and dentally underserved populations. Certification criteria for approved sites and selection criteria for applicants should reflect the intent of the Legislature to maximize the use of telehealth technologies to the benefit of Californians with difficulty obtaining health care.

OTHER STATUTORY RECOMMENDATIONS

8. Require telehealth equipment and software vendors who seek to contract with the State of California to show that their products comply with current telehealth industry interoperability standards.

SEC. 19. Section 12114 is added to the Public Contract Code, to read:

12114. All vendors and/or manufacturers wishing to contract to provide equipment or software to a State or local agency for use in facilitating the provision of telehealth services, as defined in Business and Professions Code section 2209.5, must assure that the equipment or software meets the current industry standards for interoperability.

9. Require CalPERS to include telehealth services information in health benefits collateral materials for all beneficiaries.

SEC. 4. Section 22863 of the Government Code is amended to add subsection (d), to read:

22863. (a) The board shall make available to employees and annuitants eligible to enroll in a health benefit plan information that will enable the employees or annuitants to exercise an informed choice among the available health benefit plans. Each employee or annuitant enrolled in a health benefit plan shall be issued an appro-

appropriate document setting forth or summarizing the services or benefits to which the employee, annuitant, or family members are entitled to thereunder, the procedure for obtaining benefits, and the principal provisions of the health benefit plan.

(b) The board shall compile and provide data regarding age, sex, family composition, and geographical distribution of employees and annuitants and make continuing study of the operation of this part, including, but not limited to, surveys and reports on health benefit plans, medical and hospital benefits, the standard of care available to employees and annuitants, and the experience of health benefit plans receiving contributions under this part with respect to matters such as gross and net cost, administrative cost, and utilization of benefits.

(c) The board shall, with the advice of and in consultation with persons or organizations having special skills or experience in the provision of health care services, study methods of evaluating and improving the quality and cost of health care services provided under this part.

(d) At open enrollment, the board shall distribute to all employees and annuitants information about the benefits of telehealth, as defined in Section 2290.5 of the Business and Professions Code, and the coverage for telehealth offered by each health benefit plan, including participating providers utilizing telehealth.

SEC. 5. Section 22953 of the Government Code is amended to add a new subsection (d), to read:

22953. (a) The state, through the Department of Personnel Administration, the Trustees of the California State University, or the Regents of the University of California may contract, upon negotiations with employee organizations, with carriers for dental care plans for employees, annuitants, and eligible family members, provided the carriers have operated successfully in the area of dental care benefits for a reasonable period or have a contract to provide a health benefit plan pursuant to Section 22850. The dental care plans may include a portion of the monthly premium to be paid by the employee or annuitant. Dental care plans provided under this authority may be self-funded by the employer if it is determined to be cost-effective.

(b) An employee or annuitant may enroll in a dental care plan provided by a carrier that also provides a health benefit plan pursuant to Section 22850 if the employee or annuitant is also enrolled in the health benefit plan provided by that carrier. However, nothing in this section may be construed to require an employee or annuitant to enroll in a dental care plan and a health benefit plan provided by the same carrier.

(c) No contract for a dental care plan may be entered into unless funds are appropriated by the Legislature in a subsequently enacted statute. If a dental care plan is self-funded, funds used for that plan shall be considered continuously appropriated, notwithstanding Section 13340.

(d) At open enrollment, the Department of Personnel Administration shall provide information on the benefits of telehealth, as defined in Section 2290.5 of the Business and Professions Code, and coverage for telehealth offered by each dental care plan, including participating providers utilizing telehealth.

SEC. 23. Sections 3041 and 4980.43 of the Business and Professions Code; Sections 78910.10 and 101041 of the Education Code; Sections 1367, 1375.1, 12149.5, and 127620 of the Health and Safety Code; Sections 10123.13 and 10123.147 of the Insurance Code; and Sections 14132.725 and 14132.73 of the Welfare and Institutions Code, are all amended to change the term “telemedicine” to “telehealth” wherever the term “telemedicine” is used therein.

Appendix C: Glossary

American Recovery and Reinvestment Act of 2009 (ARRA)

—Stimulus package enacted by Congress in February 2009. ARRA was meant to create jobs and promote consumer spending during the recession; it included workforce development funds for individual states.

Asynchronous (*see also Store and Forward*)—Technologies that electronically store and transmit (forward) medical information, such as pre-recorded videos, digital images, and electronic documents, among separate physical locations.

Cal eConnect—A non-profit, California public benefit corporation designated by the State of California to lead a collaborative process for ensuring the meaningful use of electronic health information exchange (HIE) in California.

California Office of the Patient Advocate (OPA)—An independent state office established in conjunction with the Department of Managed Health Care, OPA was created to represent the interests of health plan members, and to promote transparency and quality health care by publishing an annual Quality of Care Report Card. The OPA has three primary functions: consumer education, public reporting, and collaboration.

California Public Employees' Retirement System (CalPERS)—Provides retirement and health benefits to more than 1.6 million public employees, retirees, and their families, and more than 3,000 employers.

California Telehealth Network (CTN)—An organization with the goal of providing managed, sustainable, medical-grade broadband access to community anchor institutions throughout California, through a high-speed network to academic centers, data centers, application service providers and insurers. The CTN will form the basis for a technology-enabled health care system.

Centers for Medicare & Medicaid Services (CMS)—The federal agency that administers the Medicare and Medicaid insurance programs.

Critical Access Hospital (CAH)—A hospital that is certified to receive cost-based reimbursement from Medicare.

Current Procedural Terminology (CPT)—Code numbers that are assigned to every task and service a medical practitioner provides to a patient, including medical, surgical, and diagnostic services. They are used by insurers to determine the amount of reimbursement that a practitioner will receive by an insurer.

Department of Managed Health Care (DMHC)—A California state agency under the Business, Transportation and Housing Agency, DMHC is an HMO watchdog whose mission is to ensure quality health care in managed health care plans, by responding to consumer complaints, regulating and disciplining health plans, and offering free consumer assistance.

Distant Site (*see also Hub Site*)—The location of a physician or other licensed practitioner at the time a medical service is delivered via a telecommunications system.

Electronic Health Record (EHR)—A longitudinal electronic record of patient health information generated by one or more encounters in any care delivery setting. Included in this information are patient demographics, progress notes, problems, medications, vital signs, past medical history, immunizations, laboratory data, and radiology reports.

Federally Qualified Health Center (FQHC)—A type of provider defined by the Medicare and Medicaid statutes. FQHCs include all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC Look-Alikes. Requirements for

Indian Health Service funded FQHCs may differ from the requirements for FQHCs receiving Section 330 grants, and for FQHC Look-Alikes.

Fee-For-Service (FFS)—A payment mechanism in which a provider is paid for each individual service rendered to a patient.

Health Information Exchange (HIE)—Mobilization of health care information electronically across organizations within a region, community, or hospital system. HIE provides the capability to electronically move clinical information among disparate health care information systems, while maintaining the meaning of the information being exchanged.

Health Information Technology (HIT)—Provides the umbrella framework to describe the comprehensive management of health information and its secure exchange among consumers, providers, government, and other entities.

Health Information Technology for Economic and Clinical Health Act (HITECH Act)—A component of the American Recovery and Reinvestment Act of 2009, which contains approximately \$19 billion to increase the use of electronic health records (EHRs) by physicians and hospitals.

Health Workforce Pilot Project (HWPP)—A program, administered by the Office of Statewide Health Planning and Development, that allows organizations to test, demonstrate, and evaluate new or expanded roles for health care professionals, or new healthcare delivery alternatives, before changes in licensing laws are made by the Legislature..

Hub Site (see also Distant Site)—The location of a physician or other licensed practitioner at the time a medical service is delivered via a telecommunications system.

Legislative Analyst Office (LAO)—Non-partisan office that provides fiscal and policy advice and analyses to the California State Legislature.

Medi-Cal—California's Medicaid program, administered by the State Department of Health Care Services, which provides health insurance and long-term care coverage to low-income children and their parents, and elderly and disabled people

in the state. Funding is provided by both state and federal governments.

Medi-Cal EHR Incentive Program—Established by the Health Information Technology for Economic and Clinical Health Act, this program aims to transform the nation's health care system and improve the quality, safety, and efficiency of patient health care, through the use of electronic health records. Medi-Cal is in the process of developing a system to manage incentive payments for California's eligible providers.

Medicare—A federal social insurance program administered by the Centers for Medicare & Medicaid Services,, which provides health insurance to people age 65 and over, or who meet other specified criteria.

Metropolitan Statistical Areas (MSAs)—U.S. government classification for a free-standing urban population center, with a population in the urban center of at least 50,000, and a total MSA population of 100,000 or more.

Office of Statewide Health Planning and Development (OSHPD)—A department in the California Health and Human Services Agency, OSHPD administers programs to promote health care accessibility, through analyzing California's health care infrastructure, and to promote a diverse and competent health care workforce; provides information on health care outcomes; assures the safety of health care buildings; insures loans to encourage the development of health care facilities; and facilitates development of sustained capacity for communities to address local health care issues.

Originating Site (see also Spoke Site)—The location of a patient at the time a medical service is furnished via a telecommunications system. Medical personnel may be needed to facilitate the delivery of this service.

Patient Protection and Affordable Care Act (ACA)—The federal health care reform act, signed into law Mar. 23, 2010. Accompanying the ACA is the Health Care and Education Reconciliation Act of 2010, signed into law Mar. 30, 2010.

Practitioner—One who has met the requirements of, and is engaged in, the practice of medicine, dentistry, or nursing.

Primary Care Provider (PCP)—A health care practitioner who sees people that have common medical problems. A PCP is usually a doctor, but may be a physician assistant or a nurse practitioner.

Prospective Payment System (PPS)—A method of reimbursement in which Medicare or Medicaid payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived from the classification system of that service. CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Song-Brown—The Song-Brown Health Care Workforce Training Act (Song-Brown Program) was established in 1973 under the California Health and Safety Code, to increase the number of health professional training slots in established medical schools. The program encourages universities and primary care health professionals to provide health care in medically underserved areas, and provides financial support to family practice residency, nurse practitioner, physician assistant, and registered nurse education programs statewide.

Spoke Site (*see also Originating Site*)—The location of a patient at the time a medical service is delivered via a telecommunications system. Medical personnel may be needed to facilitate the delivery of this service.

Store and Forward (*see also Asynchronous*)—Technologies that electronically store and transmit (forward) medical information, such as pre-recorded videos, digital images, and electronic documents, among separate physical locations.



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