Delivering on the Promise of Telehealth to Improve Health Status in California
Background for Fact-Finding Listening Conferences
October 22, 2020 and December 2, 2020

The mission of the California Emerging Technology Fund (CETF) as directed by the California Public Utilities Commission is to close the Digital Divide in California by accelerating the deployment and adoption of broadband (a generic term for high-speed Internet infrastructure including both wireline and wireless networks and technologies). Research shows that one of the most valued uses of the Internet is to seek healthcare information and connect with health and medical care providers. Thus, supporting and promoting the use of Telehealth is a major strategy to help close the Digital Divide.

The COVID-19 pandemic shelter-in-place and social distancing orders exposed digital inequities and spotlighted the need for all Californians to be able to use telehealth. It illuminated the imperative for investments in constructing high-speed Internet infrastructure capable of supporting telehealth services and the imperative for getting all residents online with appropriate computing devices and functional digital literacy. The Digital Divide has become a "Digital Cliff" with residents falling off into deeper poverty and greater isolation. Clearly, although much progress has been made in advancing Telehealth and the federal government issued waivers that removed significant hurdles, California has not optimized the use of Telehealth to close gaps for medically-underserved communities and economically-segregated neighborhoods, which also are home to the most digitally-disadvantaged residents.

Further, technology is only a tool—powerful and empowering—but not the end game. It is essential for policymakers who strive to achieve Digital Equity to understand how to effectively integrate the use of technology into all institutions and systems, including health and medical care. Therefore, CETF and partners are convening Fact-Finding Listening Conferences to gather data and input for an Action Plan to inform State and federal policymakers about how to optimize the use of Telehealth in California.

Vision Goal for Telehealth in California
Optimize the use of Telehealth to augment and enhance health and medical care for all California residents, especially those who are medically-underserved, to improve individual patient outcomes and overall health status.

Purpose of Fact-Finding Listening Conferences
- Understand the status of Telehealth in California.
- Identify the gaps and barriers to optimizing Telehealth to improve health status for Californians.
- Develop an Action Plan to advance Telehealth policy and funding in California.

To: The Honorable Gavin Newsom, Governor, State of California
Cc: Dr. Alice Chen, Deputy Secretary for Policy, California Health and Human Services Agency
Richard Figueroa, Deputy Cabinet Secretary
Dr. Mark Ghaly, Secretary, California Health and Human Services Agency
Dr. Brad Gilbert, Director, Department of Health Care Services
Tam Ma, Deputy Legislative Secretary, Office of the Secretary
Dan Southard, Deputy Director of the Office of Plan Monitoring, Department of Managed Health Care
Mike Wilkening, Special Advisor on Innovation and Digital Services, Office of the Governor
From: California Telehealth Policy Coalition
Date: April 30, 2020
Re: **Additional Recommendations To Quickly Promote the Use of Telehealth In California During the COVID-19 Pandemic**

The California Telehealth Policy Coalition thanks the steps Governor Newsom and state agencies have already taken during the COVID-19 state of emergency to facilitate the use of telehealth. This includes guidance documents concerning the expansion of telehealth coverage and payment parity from the Department of Health Care Services (DHCS), the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). Additionally, we appreciate the Governor's executive actions that have promoted the use of telehealth by relaxing the enforcement of state health privacy and security laws to ensure alignment with federal policy at this time.

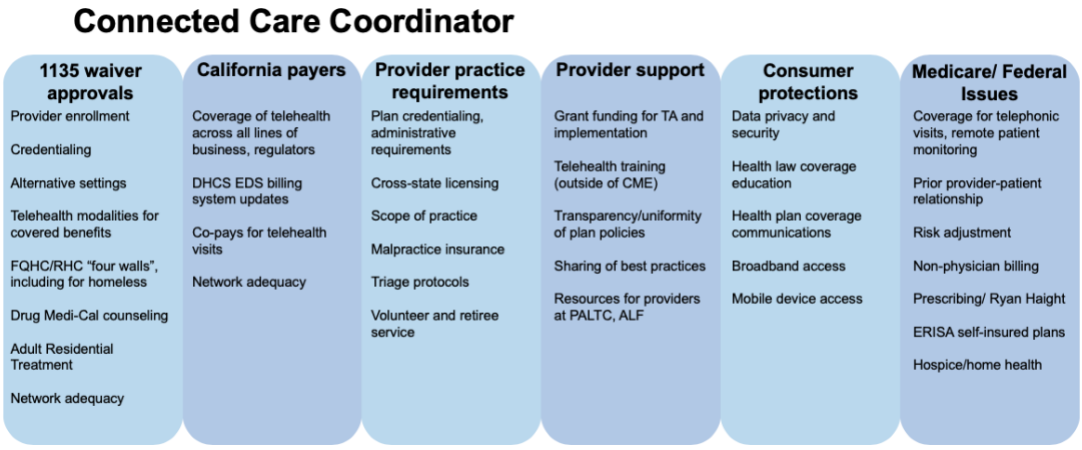
As a group of over 70 organizations dedicated to advancing telehealth policy in California, we respectfully ask that the Governor and state agencies take the following actions to continue to advance the spread of safe, secure and clinically appropriate telehealth in California.

1. **Create a "connected care coordinator" position within the California Health and Human Services Agency.**

We recommend that the California Health and Human Services Agency (CHHS) create a permanent position to coordinate efforts around telehealth and data sharing. With the rapid policy changes occurring in telehealth coverage, interoperability rules and privacy law enforcement, it has been difficult for providers to keep track of reimbursement policies across payers, especially when providers are dealing with diverse populations who have a payer mix. There is a need for consistency across all payers regulated by the state on coverage and reimbursement, and our Coalition members identified this need at our 2019 annual meeting coming out of the wildfire season. This individual can help coordinate efforts among state agencies around the need for standardization of telehealth coverage, how to capture telehealth in quality metrics, how to troubleshoot billing questions,

maintain a live site for health consumer communications, and troubleshoot questions around data sharing and privacy considerations.

For example, the connected care coordinator's competencies can be defined by subject areas affecting telehealth and serve as a source of reliable information for payers, providers, and consumers. The figure below outlines these subject areas and their related issues.



2. **Provide implementation and technical assistance funding for health care providers and local education agencies.**

We ask that the Governor appropriate $5 million in funds from emergency funding bill SB 89 to support implementation and technical assistance for telehealth. In particular, community health centers, local education agencies, medical groups, and independent medical practitioners have some of the highest need for this funding right now. While these organizations and facilities face the growing pressure of falling revenue and/or government sources of funding to provide essential health care services and education, they are swiftly looking to remotely provide ongoing health care services and supports to their patients and students. Many of these organizations have never previously used telehealth and do not have the internal financial and human resources to implement user-friendly, safe and secure telehealth solutions during COVID-19. Implementation and technical assistance funding would help fill this immediate need.

3. **Support funding for broadband and mobile device access to bridge the digital divide.**

We also ask that the Governor dedicate $100 million from emergency funding bill SB 89 to support access to broadband internet access for Californians who currently lack access to high-speed internet. 2017 data from the Public Policy Institute of California reveals that only 74% of

Californians have access to broadband at home.[1] This digital divide persists across demographics, including for communities of color, lower-income Californians, and those without a college degree. Internet access is critical for all Californians during shelter in place and for the foreseeable future as our state continues to promote social distancing measures, for health care and for other critical services like remote learning. Health care providers and patients will need internet access to utilize the telehealth services that will keep them out safely out of medical offices where clinically appropriate.

To complement broadband funding, we ask that the Governor appropriate $2 million from SB 89 funding to bridge the digital divide and assist low-income Californians in obtaining smart phones and tablets and subsidize their related monthly phone bills. Many providers and patient have had to resort to using telephone visits for remote telehealth visits instead of live video telehealth. Access to a smartphone addresses not just the issue of access to live video, but also ability to access the patient data portal, schedule appointments and send images via store-and-forward technology to providers. This initiative could be launched in tandem with efforts to increase access to remote learning

4. **Fund the Department of Health Care Service and California Department of Education's creation of a school telehealth stakeholder group under AB 2315 (2018).**

We request that the Governor dedicate $300,000 of SB 89 emergency funding toward implementation of AB 2315 (2018) to provide schools guidelines on how to use telehealth services for mental and behavioral health. In tandem, the Governor should request the California Department of Education (CDE) and the Department of Health Care Services (DHCS) fully implement AB 2315 (2018, Quirk-Silva), by jointly developing and issuing detailed guidance to school districts, school health providers, and families on how they can use telehealth to deliver mental and behavioral health services to students. Local education agencies are quickly working to find telehealth solutions that are HIPAA and FERPA compliant and understand how they can facilitate billing using these platforms. Although Governor Brown signed AB 2315 into law in 2018, DHCS and CDE have still not formed the requested stakeholder group or published the required guidance on how schools can use telehealth. We believe funding the state agencies to resource this project and work expeditiously to publish a guidance is sorely needed at this time.

5. **Create meaningful consumer information on telehealth access in California.**

The administration should work with the California Health and Human Services Agency (CHHS) to maintain a public website with up-to-date information to consumers on what telehealth is and how telehealth can access telehealth through their providers and health plans. Consumers need a comprehensive and accurate resource to reference during COVID-19, and CHHS can play a

[1] Public Policy Institute of California, Just the Facts: California's Digital Divide (March 2019), https://www.ppic.org/publication/californias-digital-divide/.

role in facilitating the spread of accurate information to Californians. This resource could include information on what telehealth is, health plan and insurance coverage, how consumers can find out if their provider has telehealth, and how telehealth can help them during COVID-19.

6. **Loosen DHCS Medi-Cal Managed Care Plan Texting Filing Requirements.**

We request that the Governor works with DHCS to pause or otherwise expedite the approval of Managed Care Plan texting programs with their members. In 2019, DHCS implemented a filing and approval requirement for texting programs with plan members. However, several plans have reported that approval of texting programs can take upwards of four months to get approved, a time period far too long during the pandemic to be able to stand up a texting program. The current pandemic requires that plans are able to maintain communications with members and send them much-needed information about COVID-19, telehealth benefits, and other crucial information.

7. **Allow for out of state providers to practice in California via telehealth during the emergency.**

Governor Newsom should sign an executive order allowing health care providers licensed in another state during the current emergency to provide services within their scope of practice via telehealth to Californians while located in another state. The Governor should consider the Emergency Management Assistance Compact (EMAC) model executive order in doing so.[2] Signing this executive order would augment California's existing health care workforce with out of state providers to ensure that Californians continue to receive the care they need via telehealth, even during hospitalization surges.

8. **Request the Department of Health Care Services and the Department of Managed Health Care create a stakeholder group on network adequacy.**

We request that the Governor encourage DHCS and DMHC to create stakeholder groups focused on network adequacy. Specifically, these stakeholder groups should be focused on how these agencies will revise their network adequacy enforcement during COVID-19 and how network adequacy methodology should be improved to account for our emerging health care delivery system in which telehealth is playing a much larger role. Existing network adequacy standards focus on timely access, time and distance standards and other aspects of care such as language access. Neither department has a formal policy for approving networks relying largely on telehealth for access to care. The COVID-19 pandemic presents an opportune time to revisit network adequacy and determine what factors could be incorporated into approving networks using telehealth. Considerations can include virtual wait times for members, decreased specialty wait times for in-person care, and data sharing capabilities among network providers. Both

[2] National Emergency Management Association, Template Executive Order (April 2, 2020), https://www.emacweb.org/index.php/resources/best-practices/using-emac-for-telehealth.

departments and stakeholders can ensure consumer protections, care coordination, and payer flexibility while accommodating for the new telehealth-dominated world we are now entering.

We thank you for considering our recommendations. Please send any questions or concerns to Robby Franceschini at robby.franceschini@bluepathhealth.com.

Sincerely,

The California Telehealth Policy Coalition

TELEHEALTH IN CALIFORNIA: LEGISLATIVE HISTORY

Center for Connected Health Policy
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1996

AB 2780 Established minimum standards for audio and visual telemedicine systems; required DHCS report on expanded application of telemedicine as potential Medi-Cal benefits.

SB 1665 California's landmark Telemedicine Development Act of 1996 established requirements regarding telemedicine payment and provision of care.

1998

SB 922 Excluded telephone conversations and electronic mail messages from telemedicine definition; clarified laws related to medical information/records and surrogate decisions.

2000

AB 2877 Removed sunset date for the provisions in the Telemedicine Act of 1996.

2002

AB 442 Required DHCS to allow psychiatrists to receive fee-for-service telemedicine Medi-Cal reimbursement (to sunset June 30, 2004).

AB 116 Applied telemedicine provisions to dentists, podiatrists, psychologists, marriage and family therapists, and clinical social workers.

2004

AB 354 Authorized reimbursement for teleophthalmology and teledermatology by store and forward by Medi-Cal (to sunset January 1, 2009)

AB 2120 Extended the sunset date for Medi-Cal reimbursement of teleophthalmology and teledermatology by store and forward until January 1, 2013.

2006

AB 329 Authorized the Medical Board of California to establish a pilot program to expand the practice of telemedicine.

AB 1224 Added licensed optometrists to the practitioners subject to telemedicine provisions.

AB 234 Imposed a 125-hour limitation on experience earned via telemedicine for marriage and family therapist's licensure examination purposes.

2008

AB 175 Expanded the definition of teleophthalmology by store and forward to include asynchronous transmissions by a licensed optometrist, for purposes of Medi-Cal reimbursement.

SB 33 Increased the number of hours of experience required for a marriage and family therapist licensure applicant to no more than 375 hours of providing services via telemedicine.

2010

AB 1733 Clarified that telehealth provisions apply to all publicly supported programs under Medi-Cal, and PACE program; require telehealth practitioners to practice according the regulations relating to their profession.

2012

AB 415 Updated the Telemedicine Act of 1996. Replaced term "telemedicine" with telehealth; broadened range of telehealth services; expanded telehealth providers to all licensed healthcare professionals; removed limits on the location; eliminated email/telephone ban; removed other Medi-Cal restrictions; removed sunset date for store-and-forward services; eased credentialing procedures; required verbal informed consent.

2014

AB 809 Required health care providers initiating telehealth to obtain and document verbal or written consent from the patient.

AB 1174 Required Medi-Cal reimbursement for store and forward tele-dentistry.

AB 93 Added an Associate Marriage and Family Therapist to the definition of a "health care provider" under statute that applies to telehealth and the need to obtain consent.

2016

AB 2861 Allowed a licensed practitioner of the healing arts or a certified substance use disorder counselor to receive Medi-Cal reimbursement for substance use disorder services provided through telehealth.

AB 2315 Required DHCS and Dep. of Education to develop guidelines for the use of telehealth in schools.

2018

AB 744 Requires reimbursement, on the same basis, to the same extent and at the same rate as the same service provided in-person.

AB 1264 Specifies that an appropriate prior examination does not require synchronous interaction between the patient and licensee and can be acheived through telehealth.

AB 1519 Specifies that all laws and regulations governing professional responsibility, unprofessional conduct and standards of practice apply to providers who provide telehealth services.

2020

AB 1494 Specifies that during an emergency face-to-face contact is not required in an enrolled community clinic for Medi-Cal beneficiaries.

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Center for Connected Health Policy
The National Telehealth Policy Resource Center

State Telehealth Laws and Reimbursement Policies

AT A GLANCE I Fall 2020

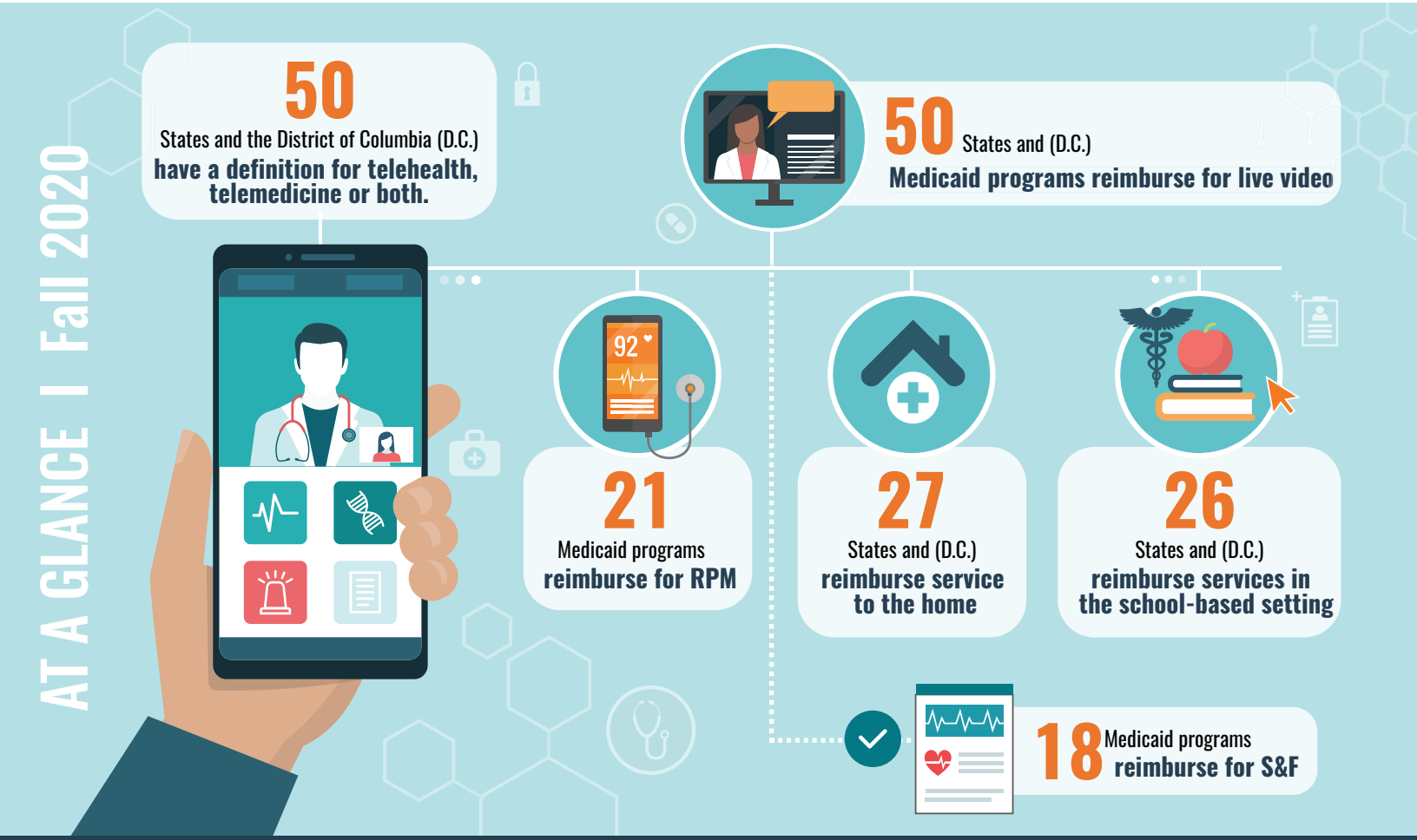
** Please note that for the most part, states continue to keep their temporary telehealth COVID-19 emergency policies siloed from their permanent telehealth policies. In instances where the state has made policies permanent, CCHP has incorporated those policies into this report, however temporary COVID-19 related policies are not included. For information on state temporary COVID-19 telehealth policies, visit CCHP's COVID-19 Telehealth Policy tracking webpage.**

Telehealth policy trends continue to vary from state-to-state, with no two states alike in how telehealth is defined, reimbursed or regulated. A general definition of telehealth used by CCHP is **the use of electronic technology to provide health care and services to a patient when the provider is in a different location.**

Medicaid Policy Trends

All 50 states and D.C. now reimburse for some type of live video telehealth services in Medicaid. Reimbursement for store-and-forward and remote patient monitoring (RPM) continues to lag behind. Eighteen state Medicaid programs reimburse for store-and-forward and twenty-one states reimburse for remote patient monitoring (RPM), with additional states having laws requiring Medicaid reimbursement for store-and-forward or RPM, yet no official written policies indicating that such policy has been implemented.

Many of the reimbursement policies that do exist continue to have restrictions and limitations, creating a barrier to utilizing telehealth to deliver services. One of the most common restrictions is a limitation on where the patient is located, referred to as the originating site. While most states have dropped Medicare's rural geographic requirement, many Medicaid programs have limited the type of facility that can serve as an originating site, often excluding a patient's home from eligibility. However, this is slowly changing, especially in this latest update as a result of the pandemic. Twenty-seven states and D.C. do now explicitly and permanently allow the home to be an eligible originating site under certain circumstances. Additionally, 26 states and DC explicitly note that their Medicaid program will reimburse telehealth delivered services in a school-based setting.



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State Telehealth Laws and Reimbursement Policies

AT A GLANCE | Fall 2020

Other Common Telehealth Restrictions

The specialty that telehealth services can be provided for

The types of services or CPT codes that can be reimbursed (inpatient office, consult, etc.)

The types of providers that can be reimbursed (e.g. physician, nurse, **etc.**)

Telephone/Audio-Only Service Delivery

5 states have added a permanent allowance for some type of telephone/audio-only delivered health care services since the COVID-19 emergency began. The addition of telephone was one of the most common COVID-19 temporary telehealth policy expansions, however not many states have taken the step to make this permanent.

Private Payer Reimbursement

43 States and the District of Columbia have laws that govern private payer reimbursement of telehealth. Some laws require reimbursement be equal to in-person coverage, however most only require parity in covered services, not reimbursement amount. Not all laws mandate reimbursement.

Consent

41 States and D.C. have a consent requirement in either Medicaid policy, law or regulation. This number has increased by two since Spring 2020.

Online Prescribing

Most states consider an online questionnaire only as insufficient to establish the patient-provider relationship and prescribe medication. Some states allow telehealth to be used to conduct a physical exam, while others do not or are silent. Some states have relaxed requirements for prescribing controlled substances used in medication assisted therapy (MAT) as a result of the opioid epidemic.

Often, internet/online questionnaires are not adequate; states may require a physical exam prior to a prescription.

More and more states are passing legislation directing healthcare professional boards to adopt practice standards for its providers who utilize telehealth. Medical and Osteopathic Boards often address issues of prescribing in such regulatory standards.

Licensure

Eight state boards issue licenses related to telehealth allowing an out-of-state licensed provider to render services via telehealth. Licensure Compacts have become increasingly common. For example:

28 States, D.C. & Guam: Interstate Medical Licensure Compact

34 States: Nurse Licensure Compact

28 States: Physical Therapy Compact

15 States: Psychology Interjurisdictional Compact (PSYPACT)

5 States: Audiology and Speech-Language Pathology Interstate Compact (ASLP-IC)

20 States: Emergency Medical Services Personnel Licensure Interstate Compact (REPLICA)

CENTER FOR CONNECTED HEALTH POLICY

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The National Telehealth Policy Resource Center

FEDERAL COVID-19 EMERGENCY ACTIONS

The following details the temporary actions taken in reaction to COVID-19, basis of those actions, expiration date and what action could be taken to preserve such policy change after the public health emergency (PHE) is over. These actions should not be considered legal recommendations.

MEDICARE			
POLICY ISSUE	**COVID CHANGE**	**EXPIRATION DATE**	**CHANGE TO MAKE PERMANENT**
Removed geographic & facility/site limitation	HR 6074	When PHE is over/expires	Statutory change needed. However, "rural" is not defined in statute and CMS could use a broader definition. Precedent for this administrative action taken in 2014. Allowing the "home" to be an eligible originating site for other services beyond ESRD & treatment for OUD with a co-occurring mental health diagnosis would require statutory change. This limitation would also mean ability for hospitals to bill outpatient services when the patient is at home would not be able to continue.
Added additional providers to eligibility list (Including FQHCs/RHCs & Allied Health Professionals)	CARES Act – HR 748/1135 Waiver	When PHE is over/expires	Statutory change needed
Allowed audio-only phone for telehealth services/Increased payment amount	CARES Act – HR 748/1135 Waiver	When PHE is over/expires	Administrative action can be used as "telecommunication system" not defined in statute
Expansion of services eligible for reimbursement	Existing law	When PHE is over/expires	Existing power for CMS to determine what services can be reimbursed if provided via telehealth
In-person requirement for renewal/check-in of certain services such as for home dialysis patients, hospice.	1135 Waiver	When PHE is over/expires	Most appear to be CMS requirements which would allow for changes to be made Administratively
Frequency limitations	1135 Waiver	When PHE is over/expires	Most appear to be CMS requirements which would allow for changes to be made Administratively

Supervision requirements	1135 Waiver	When PHE is over/expires	Most appear to be CMS requirements which would allow for changes to be made Administratively. May still encounter state level policy issues.
Temporary waiver of licensing requirement (must be licensed in patient's state)	1135 Waiver	When PHE is over/expires	Would require statutory change
PRESCRIBING CONTROLLED SUBSTANCES			
POLICY ISSUE	**COVID CHANGE**	**EXPIRATION DATE**	**CHANGE TO MAKE PERMANENT**
Allowing use of live video to prescribe without falling into one of the other exceptions	Existing law – activates when a PHE is declared	When PHE is over/expires	Already existing exception
Allowing audio-only phone to prescribe buprenorphine for opioid use disorder treatment	Current DEA authority	When PHE is over or unless otherwise specified by DEA	DEA authority to continue
HIPAA			
POLICY ISSUE	**COVID CHANGE**	**EXPIRATION DATE**	**CHANGE TO MAKE PERMANENT**
OCR to not fine for violations during PHE	Current OCR authority	When PHE is over/expires	Legislation and/or regulations likely needed
STARK LAWS			
POLICY ISSUE	**COVID CHANGE**	**EXPIRATION DATE**	**CHANGE TO MAKE PERMANENT**
Waiver of certain requirements	1135 Waiver	When PHE is over/expires	Legislation likely needed

Telehealth and COVID-19

How to Protect and Expand Telehealth Coverage in California

California Telehealth Policy Coalition

SEPTEMBER 2020

Telehealth policy falls under the purview of several state agencies and must consider all stakeholders including payers, providers, and patients. For example, quality telehealth requires policy that ensures providers are compensated for their work and that patients have access to secure broadband services. Below are more examples of the interconnected priorities that support the successful implementation of telehealth.

COVERAGE & BILLING	PROVIDER PRACTICE	PROVIDER SUPPORT	CONSUMER PROTECTIONS
• Requirements for telehealth coverage • Originating site requirements • Federally Qualified Health Center and Rural Health Center policies • State Medicaid billing system • Network adequacy considerations	• Plan credentialing and administrative requirements • Medi-Cal enrollment • Licensing • Scope of practice • Malpractice insurance • Triage protocol • Tele-prescribing	• Grant funding for technical assistance and implementation • Telehealth training in medical education • Transparency and uniformity in plan policies • Sharing of best practices	• Data privacy and security • Consumer education • Health plan member materials • Broadband access • Mobile device access

In response to COVID-19, significant telehealth policy changes were temporarily enacted on the federal and state levels. Although California had a policy landscape more favorable to telehealth than many other states did, California was not completely without its barriers at the start of COVID-19, particularly in how Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) were able to utilize telehealth.

The spread of COVID-19 has ushered in an expansion in policies supportive of telehealth. However, many policies expire when the current public health emergency ends.

Many of the temporary changes outlined on the next page have been linked to the federal declaration of a public health emergency. **Once the public health emergency ends, policy will revert back to the pre-COVID-19 state that could leave many patients who have relied on receiving services via telehealth going without, and providers and clinics who have invested in telehealth with lost investment.** This abrupt "cliff effect" could have significant impacts on patients and providers. The question now becomes, what policies should remain permanent and when must policymakers act to avoid these significant impacts?

Overview Of Telehealth Policy Changes Made

ISSUE	MEDICARE	MEDI-CAL	COMMERCIAL HEALTH PLANS
Geographic Limitation	Waived	N/A – Did not have limitation pre-COVID-19	N/A – Did not have limitation pre-COVID-19
Site Limitation	Waived	Waived restrictions for FQHCs/RHCs	N/A – Did not have limitation pre-COVID-19
Provider Limitation	Opened to all eligible Medicare Providers	Allowed greater flexibilities to providers at FQHCs/RHCs	DMHC requested plans not limit provider types eligible for reimbursement
Services Eligible	Increased list of codes from approx. 100 eligible codes to 240	DHCS required Medi-Cal Managed Care Plans to cover telehealth services to the same extent as in-person equivalents	DMHC required health plans to cover telehealth services to the same extent as in-person equivalents
Payment Parity	N/A – Medicare already paid for telehealth services at the same rate as in-person equivalents	DHCS required Medi-Cal Managed Care Plans to cover telehealth services at same rate as in-person equivalents	DMHC required health plans to cover telehealth services at same rate as in-person equivalent
Billing Frequency Limitations	Waived certain limitations	N/A	N/A
Modality	Live video & allowed some services to be delivered via audio-only phone	Expanded coverage to include phone as a modality to deliver services	Expanded coverage to include phone as a modality to deliver services
Licensing	Relaxed Medicare requirements	Limited exceptions for certain facilities that apply for a waiver through the California Emergency Services Agency	Limited exceptions for certain facilities that apply for a waiver through the California Emergency Services Agency

For California, necessary policy changes for 2021 include:

- Continue to require payment for the use of telephone to deliver services, including for FQHCs and RHCs.
- Continue to allow FQHCs and RHCs to provide services to their patients in the home.
- Expand payment parity for telehealth-delivered services to Medi-Cal Managed Care.
- Require reimbursement of remote patient monitoring and e-consult in Medi-Cal, including for FQHCs and RHCs.
- Allow FQHCs and RHCs to establish a patient-provider relationship via telehealth.
- Create more provider education materials on how to bill for telehealth.
- Generate more patient education on the availability of telehealth and how to access it.
- Update outdated forms that don't allow billing for telehealth.

California has the opportunity to learn from COVID-19 so that when our next major emergency occurs, the state and its providers are prepared to use telehealth to meet Californians' needs.

The California Telehealth Policy Coalition

The coalition is the collaborative effort of over 80 statewide organizations and individuals who work collaboratively to advance California telehealth policy. The group was established in 2011 when AB 415 (The Telehealth Advancement Act) was introduced and continues as telehealth becomes integral in the delivery of health services in California. Convened by the Center for Connected Health Policy, the coalition aims to create a better landscape for health care access, care coordination, and reimbursement through and for telehealth.

Visit the coalition online at **www.cchpca.org/about/projects/california-telehealth-policy-coalition**.