ata ACTION
Telehealth Policy to Transform Healthcare

August 4, 2026

The Honorable Mia Bonta
Chair, Assembly Committee on Health
1020 N Street, Room 390
Sacramento, CA 95814

RE: Assembly Health Committee Informational Hearing — Telehealth in California

Dear Chair Bonta and Members of the Assembly Health Committee,

On behalf of ATA Action, I am submitting the following comments in regarding the Assembly Health Committee's hearing on telehealth. We appreciate the opportunity to comment.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy and accelerating the adoption of technology-enabled healthcare. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

California has been a national leader in recognizing telehealth as an essential mode of health care delivery. The Legislature has built that framework deliberately over several sessions, and we appreciate the Committee's continued attention to how it is working in practice. Our comments below summarize the foundation the Legislature has established, identify where gaps remain, and offer recommendations for the Committee's consideration.

AB 744 (2019): Establishing Coverage and Payment Parity

AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019, was landmark legislation requiring commercial health plans and insurers to cover appropriately delivered telehealth services on the same basis and to the same extent as comparable in-person services. It further required that contracted providers be reimbursed on the same basis for the same service, whether delivered in person or through telehealth, while expressly preserving the ability of plans and providers to negotiate rates. The measure also prohibited plans from limiting coverage to services delivered through a single third-party corporate telehealth vendor – a practice that had constrained patient and provider choice and access to care.

AB 744 provided the financial predictability necessary for providers, medical groups, and health systems to invest in virtual-care infrastructure and helped move telehealth from a limited supplemental service toward an integrated component of California's healthcare delivery system. Patients have benefited from reduced travel burdens, faster access to specialists, fewer missed appointments and an improved continuity of care.

- The most recent Biennial Telehealth Utilization Report from the California Department of Health Care Services shows telehealth's continued importance to Medi-Cal patients, with telehealth

accounting for almost 10% of all medical outpatient health services and 25% of Medi-Cal telehealth utilizers filing more than five claims.

- Telehealth has also been crucial to California's Federally Qualified Health Centers (FQHCs), with more than 20% of primary care visits and 50% of behavioral health visits conducted via telehealth as of July 2024.

Building the Permanent Medi-Cal Framework: AB 133, SB 184, and AB 32

The Legislature established California's permanent Medi-Cal telehealth policy through a sequence of measures following the COVID-19 public health emergency:

- **AB 133 (Committee on Budget), Chapter 143, Statutes of 2021**, extended specified pandemic-era Medi-Cal telehealth coverage and reimbursement flexibilities through December 31, 2022. It also directed the Department of Health Care Services (DHCS) to convene a Telehealth Advisory Workgroup to inform the development of permanent post-public-health-emergency policies, including billing and utilization-management protocols.

- **SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022**, established California's permanent Medi-Cal telehealth framework, generally operative January 1, 2023. It preserved coverage of clinically appropriate services delivered through synchronous video, synchronous audio-only and asynchronous store-and-forward modalities and maintained payment parity for qualifying professional services when the service satisfies the applicable standard of care and billing-code requirements.

- **AB 32 (Aguiar-Curry), Chapter 515, Statutes of 2022**, also took effect January 1, 2023. It amended Welfare and Institutions Code sections 14132.100 and 14132.725 to permit Medi-Cal providers, including federally qualified health centers and rural health clinics, to establish a new patient relationship through an audio-only synchronous interaction when the visit involves a sensitive service, as defined in Civil Code section 56.05, or when the patient requests audio-only care or attests that they lack access to video.

Taken together, these measures moved California from temporary emergency accommodations toward a durable Medi-Cal telehealth framework. Medi-Cal now covers clinically appropriate synchronous video, synchronous audio-only, and asynchronous store-and-forward services across multiple delivery systems. It generally pays for medically necessary professional services delivered through qualifying telehealth modalities as for corresponding in-person services, provided all clinical, consent, coding and billing requirements are satisfied. Medi-Cal also covers qualifying e-consults and remote patient monitoring, subject to applicable program, provider, patient, and billing requirements. The expansion of Medi-Cal coverage for telehealth has allowed patients across the state to reap the benefits of access to telehealth care, allowing patients to get the healthcare they need when and where it works best for them.

Opportunities to Build on This Progress

California's framework represents substantial progress. However, the following areas warrant the Committee's continued attention.

I. Close remaining gaps across Medi-Cal delivery systems

Telehealth is not limited to the live video visit. Patients increasingly receive appropriate care through a range of modalities, including live video consultations, audio-only visits, secure asynchronous

questionnaires and clinical messaging, store-and-forward services, e-consults between providers, remote patient monitoring and hybrid models combining virtual and in-person care. Our organization firmly believes that licensed providers should be permitted to use any modality that will meet the standard of care for the condition presented by the patient to evaluate, diagnose, treat and form relationships with patients.

California coverage and reimbursement policy is strong, ensuring that patients and providers have access to the full suite of digital health technologies; however, there is room for improvement. As a result of AB 1264 (2019), California made clear that licensed professionals can establish relationships and prescribe medications through synchronous or asynchronous modalities. However, providers cannot establish a new patient relationship with a Medi-Cal beneficiary via asynchronous store and forward or telephonic, audio-only synchronous interactions barring department granted exceptions to this prohibition. These limitations are both unique to Medicaid beneficiaries and counter to the Federation of State Medical Boards *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (2022) which states that "a physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met."[1]

Further, Medi-Cal coverage for virtual care still varies by the program through which a patient receives care. For example, e-consults, e-visits and remote patient monitoring are not reimbursable telehealth services for federally qualified health centers, rural health clinics, or IHS-MOA clinics, notwithstanding their availability elsewhere in Medi-Cal. Patients served by the safety net — disproportionately low-income, rural, and non-English speaking Californians — therefore have narrower access to these modalities than patients served in other settings Likewise, Medi-Cal presents barriers to telehealth access for registered dieticians and International Board Certified Lactation consultants as these providers cannot enroll or bill directly on their own. This reduces access and provider choice for Medi-Cal beneficiaries in need of these services.

A patient's access to a clinically appropriate telehealth modality should not depend on whether they are served through fee-for-service, managed care, behavioral health, a federally qualified health center or a rural health clinic. We encourage the Committee to examine where program-specific distinctions continue to serve a clinical or programmatic purpose and where they simply reflect the sequence in which policy was adopted.

II. Modernize cross-state licensure to enhance Californians' access to essential healthcare services

As telehealth has become a growing part of the health care system, many states have broken down arbitrary state line barriers to care, allowing patients to see their preferred providers regardless of their location. One key area where California could seek to expand licensure flexibilities is in continuity of care, which has been endorsed by the Federation of State Medical Boards. Currently, if a California resident travels to another state to see a specialist in-person the provider cannot follow-up or continue to see the patient via telehealth without a California license. This presents difficult choices for patients and providers, patients who could face limited care or expensive travel and providers who would have to decide whether to obtain and maintain a full California license for one patient. We encourage the

[1]Federation of State Medical Boards, The Appropriate Use of Telemedicine Technologies in the Practice of Medicine, April 2022. https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf

committee to consider common-sense licensee exemptions like this one, and those enumerated in SB 1002 of 2026, to ensure continuity of care for California patients.

Additionally, California is not a member of any cross-state licensure compacts. Licensure compacts provide streamlined or expedited licensure pathways for providers to become licensed in multiple states and states across the country have used compacts to expand patient access to care, expand patient choice and help address provider shortages. We respectfully encourage the Committee to evaluate participation in appropriate interstate compacts, or alternatively to establish an expedited telehealth registration pathway that preserves the full authority of California licensing boards while improving access to qualified clinicians. Allowing out-of-state health care providers that maintain good standing in their own state the opportunity to deliver telehealth services in California will substantially increase available care options for California patients. By implementing a registration system, this legislation helps to remove arbitrary geographical barriers and avoids the costs associated with more complicated licensure regimes. This is particularly important for rural communities, behavioral health, specialty and subspecialty care, and rare disease, where workforce shortages are most acute.

III. Ease Unnecessary Barriers to Medi-Cal Enrollment for Telehealth Providers

California is also one of only a few states in the country that still requires licensed providers seeking to enroll in Medi-Cal to have a physical location in the state. When this policy was established, Medi-Cal did not anticipate the possibility of healthcare providers who are licensed in California but located in another state. While there are exceptions for behavioral health providers and providers in border communities, this still precludes a significant number of providers from enrolling to treat Medi-Cal patients, even with a California license and when accountable to California regulatory authorities. These same providers can provide care via telehealth in California to patients not on Medi-Cal, depriving patients in the most need of experts from across the country in specialty areas, contributing to ongoing provider shortages and limiting patient choice.

IV. Sustain investment in healthcare practices, technology and infrastructure necessary to innovate and deliver modern healthcare

Telehealth and digital health generally have allowed for expanded patient access to care and improved health outcomes in ways that were unimaginable just a decade ago. Through telehealth patients in rural areas can access providers that otherwise would have seen them drive several hours, working parents can get care based around their schedule instead of needing to take time off work for care and patients in disadvantaged communities and provider deserts can access a full suite of providers from the convenience of their home. None of this would have been possible without the innovation of companies based in California who have developed new models of care, virtual health platforms, and technology to support expanded patient access to care, reduced administrative burdens and empowered clinicians.

As California continues to consider the future of telehealth policy, and healthcare in general, it is essential that the state continue to cultivate an environment where innovation can thrive. Medical providers must be able to continue to access expertise and investment to expand their practice and innovate, including emerging telehealth companies who aim to reach underserved and often stigmatized populations.

Conclusion

AB 744 established a durable foundation for telehealth coverage and reimbursement in the commercial market. AB 133, SB 184, and AB 32 built the corresponding framework in Medi-Cal. Together these

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measures reflect a considered legislative judgment that telehealth is not a temporary substitute for in-person care, but an essential component of a modern, accessible, and patient-centered health care system.

ATA Action respectfully encourages the Legislature to build on that progress by:

1. Continuing to support coverage for the full range of clinically appropriate synchronous and asynchronous modalities and closing remaining coverage gaps across Medi-Cal delivery systems, with particular attention to safety-net providers;
2. Reducing unnecessary barriers to cross-state practice through licensure compacts or a streamlined telehealth registration pathway that preserves board authority;
3. Changing policy to allow out-of-state California licensed providers to enroll in Medi-Cal;
4. Ensuring that providers and entities can continue to access the expertise and investment necessary to drive innovation in new care models and technology.

We appreciate the Committee's leadership on these issues, and we recognize the contributions of Assemblymember Aguiar-Curry, a member of this Committee, whose work over several sessions has shaped much of the framework described above. ATA Action welcomes the opportunity to serve as a resource to the Committee and looks forward to working with members, staff, and other stakeholders to advance telehealth policies that improve access, quality, and health equity throughout California.

Thank you for your consideration of our comments. If you have any questions or would like to discuss the digital health industry's perspective further, please contact me at hyoung@ataaction.org.

Sincerely,

Hunter Young
Head of State Government Relations
ATA Action