Submitted via electronic email

April 5, 2024

The Honorable Mia Bonta, Chair
Assembly Committee on Health
State Capitol, Room 6005
Sacramento, CA 95814

Re: *A.B. 2726: Specialty Care Network: Telehealth and Other Virtual Services (Flora)- SPONSOR*

Dear Chairwoman Bonta,

OCHIN is proud to sponsor A.*B. 2726: Specialty Care Network: Telehealth and Other Virtual Services (Flora),* which authorizes a demonstration of a virtual specialty services network integrated with primary care providers in rural and other underserved communities designed to reduce wait times and improve outcomes for patients with Medi-Call coverage or who are underinsured. OCHIN is a national nonprofit health IT innovation and research network and our California members serve 2.2 million patients (including 674,300 who are covered under Medi-Cal) and include federally qualified health centers (FQHCs), rural health clinics, Critical Access Hospitals, local public health agencies, and school-based health programs. The demonstration would align with priority state initiatives to drive payment and delivery transformation, support care coordination, improve data exchange and reporting, while also providing a model that could test capacity building in anticipation of public health emergencies and localized and regional disasters and hazard events.

Patients covered by Medi-Cal or who are underinsured face growing wait times to see a specialist or cannot secure appointments at all. A recent OCHIN network member analysis found in California that the average wait time to see a specialist is 62 days. The average wait time varies significantly by specialty and is 51 days for behavioral health, 62 days for cardiology, 75 days for neurology, 80 days for dermatology. In the OCHIN network only about 43% of all patient specialty referrals closed for any reason between October 2022 and September 2023. Only 27% of these referrals were closed because the patient was seen by a specialist. Due to deepening clinician shortages, an aging population, and systemic barriers that disproportionately impact rural and other underserved communities (such as lack of transportation and housing insecurity) it's anticipated that these wait times will continue to increase—ultimately compromising patient health and increasing costs for patients and their families as well as the overall cost to the health care system. Efforts to improve maternal health, mental and behavioral health, complex chronic disease management, and transitions to new value-driven payment and delivery models will be hamstrung by this endemic lack of access. For rural and underserved communities, the lack of timely access to specialty care means worsening, untreated conditions that drive higher disease burden and cost to the health system. Access to virtual modalities such as telehealth, store and forward, and eConsults should have improved access to specialists as it did for primary care during the COVID-19 public health emergency (PHE),but it has not and will not without a network of specialist dedicated to serving patients in the safety-net.

Deepening specialist shortages, geographic mismatches, lack of transportation and other structural impediments as well as Medi-Cal payment rates that are not competitive with Medicare and commercial health insurers contribute to lack of timely access. However, two powerful factors include the lack of: (1) specialist networks with requisite licensure and ready willingness to accept patients covered by Medi-Cal or who are under-insured in rural and underserved communities; and (2) streamlined technological connections and technical assistance to support operational needs and coordination for specialists and primary care providers in rural and underserved communities. The lack of access to integrated specialty care for patients with Medi-Cal coverage and others who are underinsured living in rural and other underserved communities is well-documented. To drive improved health outcomes and reduce health disparities, providers with the most clinically and socially complex patients have the greatest need of timely specialty care services to manage patients with co-morbid chronic conditions facing numerous health related social needs (social drivers of health).

A.B. 2726 would fund a demonstration to drive measurable clinical efficiencies for rural and medically underserved communities in alignment with Medi-Cal initiatives. The demonstration would power scalable learnings on seamless integration of a dedicated safety-net virtual specialty care network with a patient's primary care provider through their electronic health record platform focused on rural and underserved communities. The network would provide services to patients who have coverage through federal and state programs such as Medi-Cal and Medicare as well as those who are underinsured. The bill would address these challenges by establishing and testing a virtual network to provide specialty care through a range of digital modalities, such as eConsults, telehealth, and EHR-based clinical decision support. While there is a significant evidence base to support the use of virtual modalities to improve access to care, this demonstration focuses on testing a virtual delivery model tailored to the payment and specific needs of rural and underserved communities. The demonstration would test the impact on access, health outcomes, and the role of timely specialty care access that is coordinated with primary care on costs while also providing an assessment of the impact on sustainable transition to value-based payment for providers in rural and underserved communities. A similar pilot on a smaller scale at an OCHIN member rural clinic in Oregon found that dermatology eConsults were effective in reducing follow up time for patients by an average of 45 business days with significant savings.

Thank you for your leadership. Please contact me at stollj@ochin.org if we can provide any additional information to support your efforts.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer
External Affairs