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<th>Topic</th>
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<tr>
<td>Welcome and Introductions</td>
<td>5 min.</td>
</tr>
<tr>
<td>Announcements and Committee Background</td>
<td>10 min.</td>
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<tr>
<td>Charter Approval</td>
<td>5 min.</td>
</tr>
<tr>
<td>DHCS Telehealth Policy Recommendations</td>
<td>20 min.</td>
</tr>
<tr>
<td>Communications Update</td>
<td>10 min.</td>
</tr>
<tr>
<td>Webinar and Fact Sheet Planning</td>
<td>15 min.</td>
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</tbody>
</table>
Coalition’s key guiding principles (as outlined in our charter):

**Promote access and coverage.** Policies, legislation and activities should promote access to care through telehealth and coverage of telehealth services.

**Enhance care coordination.** Policies, legislation and activities should reinforce the patient-centered medical home model and reduce care fragmentation both within and among systems.

**Promote provider and patient engagement.** Policies, legislation and activities should promote the participation of providers in efforts that improve performance and patient health outcomes, and the involvement of patients in their health care.

**Reinforce clinical quality.** Policies, legislation and activities should reinforce desirable, measurable outcomes, specifically those used by regulators and produced by standard-setting organizations.

**Ensure data privacy and security.** Policies, legislation and activities should ensure data privacy and security, particularly as those standards are prescribed by law and industry standards.
2021 Charter: Education Committee Objectives

- Educate stakeholders on telehealth and related policies issues
- Ensure regulatory follow-through on implementing and enforcing legislation
- Orienting new coalition members
- Position the coalition as a state subject matter expert on telehealth policy
- Establish charter and operational procedures for the Coalition and committee work
- Oversee Coalition fundraising
- Support marketing and branding efforts for the coalition including new member engagement
# Education Committee Work Plan 2021

<table>
<thead>
<tr>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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</thead>
<tbody>
<tr>
<td>Host webinar on a key topic</td>
<td>Host webinar on a key topic</td>
<td>Host webinar on a key topic</td>
<td>Host Policy Briefing</td>
</tr>
<tr>
<td>Develop and publish 2 fact sheets on Key Topics</td>
<td>Develop and publish 2 fact sheets on Key Topics</td>
<td>Develop and publish 2 fact sheets on Key Topics</td>
<td>Host Annual meeting</td>
</tr>
<tr>
<td>Oversee strategic communications work with regular reports from chairs</td>
<td>Oversee strategic communications work with regular reports from chairs</td>
<td>Oversee strategic communications work with regular reports from chairs</td>
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</tr>
<tr>
<td>Review and finalize charter for 2021</td>
<td>Develop a telehealth data clearinghouse on our website</td>
<td>Discuss proposed Physician Fee Schedule Changes and craft response</td>
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<tr>
<td>Chair outreach to administration and legislative staff to formally introduce the Coalition</td>
<td>Create a state telehealth report</td>
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<td>Develop and launch recruitment strategy</td>
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<tr>
<td>Coordinate on policy and initiative tracking (e.g., CalAIM, Master Plan on Aging)</td>
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</table>
Fact Sheet Process

1. Members, staff, committee members discuss fact sheet ideas at committee meetings
2. Staff create first draft of fact sheet and socialize with committee members for feedback
3. Designer develops fact sheet
4. Staff publish fact sheet on Coalition website and distributed via email
HHS Public Health Emergency likely to be extended through 2021

- Acting HHS Secretary indicated in a recent letter to state governors that the Department intends to extend the declaration of Public Health Emergency through at least end of 2021.
- All temporary Medicare and Medicaid flexibilities will remain through 2021.
- Flexibilities are still scheduled to sunset once PHE is rescinded.
- Private payors likely to also extend telehealth coverage through PHE.
# DHCS Post-COVID Telehealth Policy Recommendations Public Document

<table>
<thead>
<tr>
<th>Section Title</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background</strong></td>
<td>Background information on recent telehealth policy</td>
</tr>
<tr>
<td><strong>A Pathway Forward</strong></td>
<td>A summary of the document and guiding principles</td>
</tr>
<tr>
<td><strong>Post COVID-19 PHE Telehealth Policy Recommendations</strong></td>
<td>Overview of the telehealth coverage DHCS wants to keep or expand Post-COVID</td>
</tr>
<tr>
<td><strong>COVID-19 PHE Flexibilities Not Recommended for Continuation</strong></td>
<td>Overview of the telehealth coverage DHCS wants to revoke Post-COVID</td>
</tr>
</tbody>
</table>
| **Pre- and Post-COVID-19 PHE Telehealth Framework**                           | Matrix comparing telehealth coverage during COVID-19 to DHCS proposed changes for Post-COVID-19 telehealth coverage as well as the rationale for these recommendations. The chart is organized by modality:  
  - Synchronous telehealth  
  - Asynchronous telehealth  
  - Telephonic  
  - Virtual communications  
  - Remote patient monitoring                                                                 |
| **Next Steps and Associated Action Items**                                    | A description of tools, procedures that DHCS plans to use in order to implement these proposed changes.                                          |
Post COVID-19 PHE Telehealth Policy Recommendations Overview

- Allow specified FQHC and RHC providers to establish a new patient, located within its federal designated service area, through synchronous telehealth.
- Make permanent the removal of the site limitations on FQHCs and RHCs
- Expand synchronous and asynchronous telehealth services to 1915(c) waivers, the TCM Program and the LEA-BOP
- Add synchronous telehealth and telephonic/audio-only services to State Plan Drug Medi-Cal.
- Require payment parity between in-person face-to-face visits and synchronous telehealth modalities, when those services meet all of the associated requirements of the underlying billing code(s), including for FQHC/RHCs, FFS and Managed Care
- Expand the use of clinically appropriate telephonic/audio-only, other virtual communication, and remote patient monitoring for established patients. These modalities would be subject to a separate fee schedule and not be billable by FQHC/RHCs.
- Provides that the TCM Program and the LEA BOP will follow traditional certified public expenditure (CPE) cost-based reimbursement methodology when rendering services via applicable telehealth modalities.
<table>
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<tr>
<th>Pre-Covid-19 PHE Policy</th>
<th>Proposed Post-COVID-19 PHE Changes</th>
<th>Rationale/Considerations</th>
</tr>
</thead>
</table>
| Medi-Cal Covers in the following delivery systems:  
• Physical health (New and established)  
• FQHC/RHC – Established patients  
• Specialty mental health (SMH)  
• Dental  
• DMC-Org Delivery System (DMC-ODS)  
• LEA BOP speech therapy  
• 1915(c) waivers - case management and indirect caregiver support | **Add for the following delivery systems:**  
• FQHC/RHC – (within service area) allows new patients, removes site limitations for clinic providers and patients  
• **State Plan Drug Medi-Cal (DMC)** – allow for all covered services  
• **1915(c) waivers** – allow modality for waiver intake, ongoing reassessments, direct care services (align with physical health)  
• **LEA BOP** – allow modality for all services provided by licensed practitioners who are acting within their scope of practice  
• **TCM** – allow for all covered services  
• **Additional SMH services** | Support payment parity for all Medi-Cal covered benefits and services provided via synchronous telehealth modalities because the quality and complexity of those visits are expected to be identical under Medi-Cal policy in terms of quality, documentation, and billing |
| Reimbursement:  
• **Payment parity** when those services meet all the requirements of the underlying billing code(s), including for FQHC/RHCs, FFS and Managed Care  
• For LEA BOP and TCM services, reimbursement will be via the CPE cost-based reimbursement methodology |
## Asynchronous telehealth

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Medi-Cal Covers in the following delivery systems:</td>
<td><strong>Add for the following delivery systems:</strong></td>
<td>• Promote and further support flexibility in terms of the types of Medi-Cal covered benefits and services able to be provided via asynchronous telehealth modalities.</td>
</tr>
<tr>
<td>• Physical health (store and forward, e-consult)</td>
<td>• <strong>1915(c) waivers</strong> - applies to case management and direct care (where allowable in physical health policy)</td>
<td></td>
</tr>
<tr>
<td>• FQHC/RHC – Only for ophthalmology, dermatology, and dentistry</td>
<td>• <strong>LEA BOP</strong> - provided by licensed practitioners who are acting within their scope of practice</td>
<td></td>
</tr>
<tr>
<td>• Dental</td>
<td>• <strong>TCM</strong> – All services</td>
<td></td>
</tr>
<tr>
<td>• DMC-ODA (e-consults)</td>
<td><strong>Reimbursement:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• <strong>Reimbursement for asynchronous telehealth will be subject to a separate fee schedule</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• For LEA BOP and TCM services, reimbursement will be CPE cost-based reimbursement methodology</td>
<td></td>
</tr>
</tbody>
</table>
## Telephonic telehealth

### Pre-Covid-19 PHE Policy
Medi-Cal Covers in the following delivery systems:
- 1915(c) waivers - case management and indirect caregiver support
- SMH, most services
- DMC-ODS

### Proposed Post-COVID-19 PHE Changes
Add for the following delivery systems:
- **Providers cannot establish a patient using telephonic/audio-only modalities**
- **Physical health** (Evaluation and Management codes, other CPT codes)
- State Plan DMC – everything except initial assessment
- **All 1915(c) waivers** – align direct care services with physical health policy
- **Developmentally Disabled waiver** – allow for waiver intake, ongoing reassessments
- **LEA BOP** – provided by licensed practitioners who are acting within their scope of practice
- **TCM** – all services
- **Additional SMH services**

### Reimbursement:
- Telephonic/audio-only services would be subject to a separate fee-schedule
- Telephonic/audio-only services are not billable by FQHC/RHCs

### Rationale/Considerations
- Reduce the need for unnecessary office visits and triage
- Allow for initial assessments to see if an in-person visit is required, to help reduce access issues re: certain high-demand subspecialties.
- Given the underlying intent of and level of care provided via telephonic modalities, and types/quality services rendered, the level of complexity, and associated documentation, these interactions are not typically viewed equivalent to face-to-face in-person visits and therefore should be reimbursed at different rate.
Virtual communications or “Virtual check-ins”

<table>
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<tr>
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<tbody>
<tr>
<td>Medi-Cal Covers in the following delivery systems:</td>
<td>Add for the following delivery systems:</td>
<td>• Similar to the rationale above for telephonic/ audio only modalities, given the underlying intent of and level of care provided via virtual communication modalities, these interactions are not typically viewed as being equivalent to face-to-face in-person visits and therefore will be reimbursed using specific codes with separate rates</td>
</tr>
<tr>
<td>• Physical Health – e-visits Note: HCPCS code G2010 and code G2012 are currently billable for established patients.</td>
<td>• Physical health – add select HCPCS and CPT codes</td>
<td></td>
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<tr>
<td></td>
<td>• 1915(c) waivers – allow the use of evisits and mobile apps</td>
<td></td>
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<tr>
<td></td>
<td>• LEA BOP – may be used by licensed practitioners who are acting within their scope of practice</td>
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</tr>
<tr>
<td></td>
<td>• TCM – all services</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reimbursement:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Services would be subject to separate fee schedule, using specific codes.</td>
<td></td>
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<tr>
<td></td>
<td>• E-visits allowed with HCPCS G2061- G2063 and CPT 99421-99423</td>
<td></td>
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<tr>
<td>Pre-Covid-19 PHE Policy</td>
<td>Proposed Post-COVID-19 PHE Changes</td>
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</tbody>
</table>
| Medi-Cal does not cover RPM today. | Add for the following delivery systems:  
  - Physical health for specific procedure codes, (one-time set-up and education, device, remote monitoring of physiological parameters- billable 30 days; and interpretation and communication back to patient).  
  - Home Health (align policy with Medicare in terms of making this a covered home health benefit; See Federal Rule)  
  - All 1915(c) waivers – align direct care services with physical health policy | • Promote and further support flexibility in terms of the types of Medi-Cal covered benefits and services able to be provided via RPM.  
• Support high-quality health care services across delivery systems  
• Provide improvement in outcomes such as mortality, quality of life, and hospital and nursing facility admissions  
• Similar to the rationales above for telephonic/audio-only and virtual communication modalities, given the underlying intent of and level of care provided via RPM, these interactions are not typically viewed equivalent to face-to-face, in-person visits and therefore will be reimbursed using specific codes with separate rates.  
• This modality could help individuals remain safely in their home and be discharged early from inpatient or skilled nursing facility care |

**Reimbursement:**  
- Services would be subject to a separate fee schedule, using specific codes and allowable for use by Home Health Agencies.
As part of the governor’s budget DHCS proposes to make these outlined changes permanent. The budget also includes $94.8 million total funds ($34.0 million General Fund) to implement remote patient monitoring services as an allowable telehealth modality in fee-for-service (FFS) and managed care delivery systems.
Next Steps & Action Items: Trailor Bill language

Advancing Trailer Bill Language: DHCS proposes TBL for 2021-22:

• Add virtual communication, telephonic/audio-only and RPM as allowable modalities under Medi-Cal.

• Allow State Plan DMC providers to deliver all allowable substance use disorder (SUD) services via synchronous telehealth and telephonic modalities.

• All reimbursable services provided through various telehealth modalities shall comply with privacy and security requirements.

• Expand the definition of an FQHC and RHC visit to include synchronous interaction. o Allow FQHC and RHC providers to establish new patients through synchronous telehealth.

• Reimbursement changes: in-person and synchronous telehealth payment parity in FFS and managed care (unless alternate agreements are in place with network providers).

• Allow the use of telehealth to meet network adequacy standards in Medi-Cal managed care health plans, County Mental Health Plans, Dental Managed Care plans and DMC-ODS.

• Revise Alternate Access Standards submission and review process and to postpone the network adequacy sunset provision until 2026.
Next Steps & Action Items: SPAs and 1915(c) and CA Regulations

**State Plan Amendments (SPAs):** As necessary, DHCS will submit SPAs to CMS for necessary federal approvals, which will have an effective date of July 1, 2021.

**1915(c) Home and Community Based Services (HCBS) Waivers:** DHCS will amend existing 1915(c) HCBS waivers, which will be effective July 1, 2021, and allow for telehealth and other virtual communication modalities and amendment waiver contracts, as necessary.

**DHCS will promulgate state regulations including:**

- **TCM:** expand the definition of an “encounter” to include additional telehealth modalities.
- **SMH:** Revise CCR to comply with any SPAs that include synchronous telehealth and telephonic/audio-only modalities to clarify additional SMH services are eligible for these modalities.
- **State Plan DMC:** Modify to allow State Plan DMC providers to deliver all allowable SUD services via synchronous telehealth and telephone/audio-only modalities.
Next Steps & Action Items: Policy Guidance and Stakeholder engagement

**Developing and Issuing Policy Guidance:** Through calendar year 2021, DHCS will develop and issue clear policy guidance for Medi-Cal providers across delivery systems, which will include, but not be limited to, the following:

- Updates to Medi-Cal Provider Manual and other policy/procedure documents, such as LEA BOP, TCM Plan letters and Policy letters
- Creation of new and amendments to existing provider and patient education materials,
- Execution of contract amendments, as appropriate across various delivery systems

**Initiating Stakeholder Engagement:** DHCS has not provided full details on how it plans on engaging stakeholders
State Legislative Update

<table>
<thead>
<tr>
<th>Bill No.</th>
<th>Coalition Support?</th>
<th>Recent Developments</th>
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</tr>
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<tbody>
<tr>
<td><strong>AB 14</strong></td>
<td>✅</td>
<td>Introduced 12/7</td>
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<tr>
<td><strong>AB 457</strong></td>
<td></td>
<td>Introduced 2/8</td>
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<tr>
<td>(Santiago)</td>
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</tr>
<tr>
<td><strong>SB 4</strong></td>
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<td>(Gonzalez)</td>
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**Upcoming Hearings:**

- **Assembly Health Informational Hearing on Telehealth:** February 16 at 2:30pm
  - Speakers include Mei Kwong, CCHP and Dr. Yohualli Balderas-Anaya, UCLA Health
  - *Public comment is anticipated at 4:30pm*

- **Assembly Health Health Information Exchange Informational Hearing:** March 2 at 1:30pm
  - *Public comment is anticipated at 3:30pm*

Meeting information available on the Assembly Health website: [https://ahea.assembly.ca.gov/hearings](https://ahea.assembly.ca.gov/hearings)
Coalition Communications Update
Nikki Paschal and Maya Polon, Paschal Roth Public Affairs
Webinar Planning- Draft ideas

**Webinar 1 Proposal:** Review of the Governor’s budget proposal for telehealth

- Timing: Late February
- Panelist ideas: DHCS representative, LAO representative, two panelist “reactors”

**Webinar 2 Proposal:** Audio-only telehealth

- Timing: Late March/ April
- Panelist ideas: Patient representative; telehealth researcher (e.g., Lori Uscher Pines, RAND); Health system representative (e.g., Farhan Fadoo, CEO, SJGH); Health plan representative (e.g., Malaika Stoll, BSC)
Next Steps

Meetings

- Legislation Committee Meeting: 2/11 at 1:00
- Broadband Committee Meeting: 2/16 at 1:00
- Monthly Meeting: 2/19 at 1:00

Hearings

- Assembly Health Informational Hearing, 2/16 at 2:30

Committee Activities

- Fact sheet(s) for webinar #1 to be circulated ahead of webinar
- Finalize plans for webinar #2 at next committee meeting
Appendix
Governor’s proposed budget includes funding for Coalition priorities, including Covid-19 flexibilities and RPM

- **Medi-Cal coverage of continuous Glucose Monitors: $12M** to “add continuous glucose monitors as a covered Medi-Cal benefit for adult individuals with type 1 diabetes, effective January 1, 2022. This proposal increases health equity.”

- **Telehealth flexibilities in Medi-Cal: $94.8M** to “make permanent certain telehealth flexibilities authorized during COVID-19 for Medi-Cal providers and to add remote patient monitoring as a new covered benefit, effective July 1, 2021. This effort will expand access to preventative services and improve health outcomes, thereby health equity.”

DOF Proposed Budget: http://www.ebudget.ca.gov/
Governor’s proposed budget also includes funding for HIE and broadband

- **Utilizing health information exchange**: “The Administration envisions an environment where health plans, hospitals, medical groups, testing laboratories, and nursing facilities—at a minimum, as a condition of participating in state health programs such as Medi-Cal, Covered California and CalPERS—contribute to, access, exchange, and make available data through the network of health information exchanges for every person.”

- **Broadband**: “California will meet these challenges with a coordinated state effort based on key actions over the next five years to provide every Californian a reliable and affordable connection… The [State Action] Plan, adopted in December, lays out three main goals: that all Californians have access to high-performance broadband at home, that all Californians can afford broadband and the devices necessary to access the Internet, and that all Californians can access training and support to enable digital inclusion…”
  - **Lifeline Program**: est. $399M in expenditures in 2021-22 (inc. from $411M in 2020-21)
  - **California Advanced Services Fund**: est. $81.3M in expenditures (same as 2020-21)
## California Legislative Developments

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Upcoming hearing: February 16 Assembly Health Hearing on Telehealth (Tentative, to be confirmed)
Q1 Webinar Topic

What should our 2021 webinar topics be?

Ideas
• Governor’s budget overview
• Broadband and telehealth
• Telehealth and network adequacy
• Telehealth for small children

2020’s Webinar Topics:
• Telehealth in PALTC Settings
• Telehealth and Substance Abuse
• Using Telehealth for Mental Health During Covid-19
• Coding for COVID-19 How to Bill for Telehealth During the COVID-19 Pandemic
• Telehealth Triage: How to Use Telehealth During COVID-19
What should our 2021 Fact Sheets be, to align with webinars where possible?
Next Steps

- Provide charter feedback by Friday, January 29
- Develop webinar materials, schedule date and reach out to speakers
Subgroup Administration

- **Meeting Cadence:** Monthly through the end of 2020
- **Membership:** Open to all Coalition members
- **Staff Contacts:**
  - Mei Kwong: meik@cchpca.org
  - Robby Franceschini: robb.franceschini@bluepathhealth.com
Coalition Priorities for 2021

- Make temporary coverage expansions permanent and expand access to new modalities
- Build the evidence base for telehealth in California
- Bridge the digital divide and addressing health equity
- Advance state leadership on telehealth and health IT
Priority 1: Make temporary coverage expansions permanent and expand access to new modalities

Example work:

- Support payment parity for Medi-Cal Managed Care
- Support remote patient monitoring coverage for Medi-Cal and commercial plans
- Support continued FQHC/RHC coverage for telehealth
- Work with members to highlight patient stories on webinars, other materials aimed at policymakers and consumers
Priority 2: Build the evidence base for telehealth in California

Example work:

- Showcase research on monthly calls
- Develop a telehealth data clearinghouse on our website and leverage members’ data dashboards
- Release annual report for DHCS and the state legislature - align publication date with Fall Briefing
- Host Capitol Briefing in Fall 2021 (third annual)
- Host and co-host educational webinars. Key Topics: Equity, Telehealth & Triple Aim, RPM, broadband policy/Lifeline program, interoperability
Priority 3: Bridge the digital divide and addressing health equity

Example work:

- Promote heightened standards for broadband access and consumer subsidies for smartphones and internet access
- Demonstrate and build evidence base on the efficacy and quality of telephonic visits
- Track and highlight distribution of internet access/telehealth across communities (i.e., geographies, communities of color, the disabled community, older adults, teens and young adults)
- Identify resources for additional telehealth adoption including grants and technical assistance
Priority 4: Advance state leadership on telehealth and health IT

Example work:

- Advocate for state coordination on telehealth and related IT issues (i.e., telehealth integrations, public health reporting, health information exchange)
- Track regulatory requirements and required updates
- Conduct outreach to state agencies on telehealth policy in 2021
- Emphasize the need for modernization of telehealth and data sharing through state policy initiatives (i.e., CalAIM, Managed Care procurement)