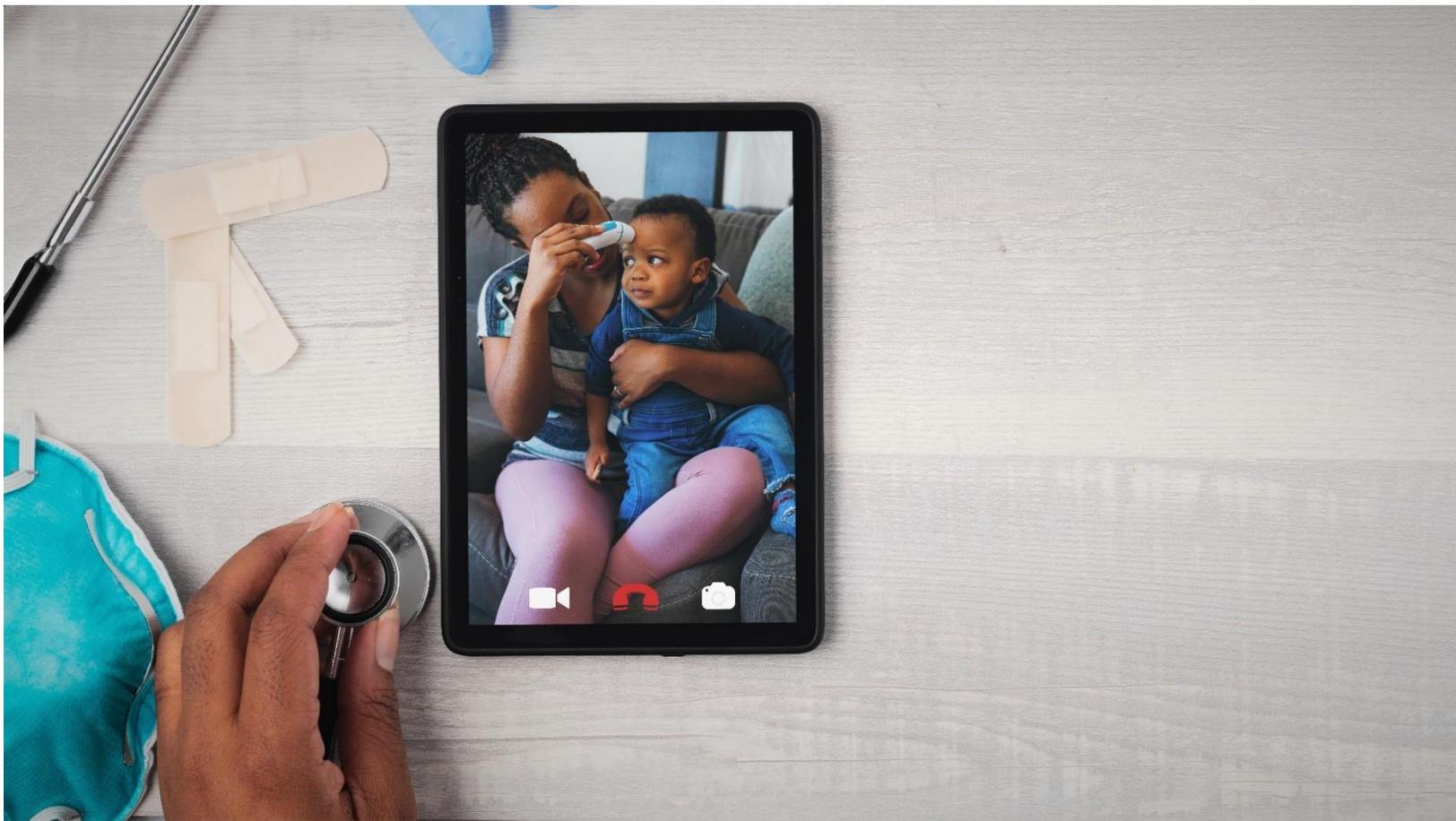


The Future of State Telehealth Policy



NATIONAL
GOVERNORS
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Table of Contents

Executive Summary.....3

Introduction4

Licensure, Scope of Practice and Supervision.....6

 Licensure portability 6

 Interstate compacts 6

 Scope of practice 7

 Summary of Interstate Licensure Compacts..... 9

Coverage of Services Offered Via Telehealth10

 Eligibility for reimbursement for providing services via telehealth 10

 Services offered via telehealth 10

 Modalities for services offered via telehealth 11

 Distant and originating sites..... 11

 Establishing patient-provider relationships 12

Payment for Telehealth Services.....12

 State policies on payment for telehealth services before COVID-19 12

 Implications of fee-for-service payments for telehealth on cost..... 13

 Moving beyond fee-for-service 13

Narrowing the Digital Divide.....14

 Low-income and rural residents’ access to broadband and technology..... 15

 Accessible technology for individuals with disabilities 15

 Technology and digital literacy training for older adults 15

 Translation services for populations with limited English proficiency..... 16

 Considerations for individuals with serious mental illness..... 16

Interoperability Across Systems.....17

Privacy Protections.....18

Stakeholder Engagement.....18

Federal Telehealth Policies19

 Teleprescribing for medically assisted treatment for substance use disorder treatment .. 19

 National Health Service Corps.....20

 HIPAA20

Conclusion.....20

Acknowledgements.....21

Executive Summary

The onset of the COVID-19 pandemic brought an unprecedented level of attention to telehealth as a mechanism for delivering health care services. The federal government and states provided temporary modifications to many policies to make it easier for health care providers to be reimbursed for services provided via telehealth, which resulted in a significant uptick in services, particularly early in the pandemic. Major changes centered on licensure, scope of practice, supervision, coverage, reimbursement and modalities for delivering services via telehealth.

As states begin to think about long-term policies, policymakers may consider how telehealth impacts access, cost and quality of care. Experience during the pandemic may help justify permanence of some flexibilities, particularly surrounding the types of providers who may be reimbursed, services that are covered and distant and originating sites that are permitted. However, other policies, such as payment parity, may receive less traction, especially given rising health care costs and state budget shortfalls. As states look to incentivize greater provider accountability for outcomes, telehealth flexibilities may be a lever to encourage participation in risk bearing value-based payment arrangements. In addition, there remains significant opportunity to close the digital divide that can exacerbate inequities in health care access for individuals who may experience difficulties engaging in telehealth.

This paper summarizes the types of policy flexibilities provided by states and the federal government during the COVID-19 pandemic and longer-term considerations for Governors regarding the impact of such policies on care delivery and payment with the goal of helping policymakers assess the appropriateness of policy permanence beyond the pandemic.

Introduction

Health care providers have been providing services via telehealth for decades with increasing levels of technological sophistication over time.¹ However, it was not until the COVID-19 pandemic reached the United States that federal, state and commercial payers created broad flexibility in many telehealth policies to facilitate physical distancing while maintaining access to health care services. In addition to providing a mechanism for individuals to receive care at home, payment parity for telehealth helped many providers stay solvent during the COVID-19 pandemic. As a result, there have been more telehealth policy changes (many of which are temporary) within the past year than in the past 20 years.² Further, use of services provided via telehealth has increased dramatically. An analysis by FAIR Health found a 3,806 percent increase in the volume of telehealth claims from private payers from July 2019 to July 2020, which is largely attributed to flexibility and awareness of telehealth during COVID-19.³ While we cannot assume that the higher uptake of telehealth will continue at the same rate post-pandemic, as patients may have felt they had little choice but to receive services virtually, payers are amassing extensive data upon which to measure outcomes in the short and long-term.⁴

Although the Centers for Medicare & Medicaid Services (CMS) regulates coverage and payment policies for Medicare, and the Drug Enforcement Administration (DEA) sets limitations on teleprescribing of controlled substances, states and territories have significant authority to set telehealth policy in Medicaid, the individual market, and through health professional licensure.*

Throughout the pandemic, states and territories have used their authority via executive order, legislation and guidance to allow greater use of telehealth with at least 50 states and territories taking action to temporarily or permanently modify policies.⁵ Although at time of publication the federal public health emergency continues and many states are renewing their emergency orders, some states have already started making permanent policy changes. As of November 24, 2020, 23 states have passed telehealth legislation that extends beyond COVID-19.^{6†}

Across states, there is wide variation in telehealth policies.‡ This differentiation also extends to policies within states by payer. In many instances, health care providers treat patients

* States have very few requirements regarding CMS approval for use of telehealth in Medicaid. If a state wishes to have payment rates or methodologies that differ from same services provided in face-to-face setting, they must submit an amendment for approval and they must submit changes regarding payment of ancillary costs (e.g. technical support or transmission charges).

† Some states have passed legislation that is permanent (or lacks an end date) while others have new laws with concrete end dates.

‡ [The Center for Connected Policy](#) tracks telehealth policies by payer (including COVID-19 flexibilities) and releases comprehensive biannual reports which detail state policy pertaining to telehealth payment, modalities, originating and distant sites.

covered by several different payers, meaning that they must comply with a range of different telehealth policies.

This issue brief is intended to help Governors, regulators and legislators evaluate telehealth policies beyond the pandemic.

Key Considerations for Governors

The following considerations can help Governors and their teams assess the potential implications of different policies:

- **Licensure** policies can be used to facilitate interstate practice and the range of health care professionals for whom such practice is permitted, including required supervision.
- **Coverage** of services provided via telehealth may be narrowly defined by policymakers or broadly defined to allow providers flexibility to determine when telehealth is appropriate.
- **Pairing payment policies and incentives** to move towards more value-based models may serve as a lever to support appropriate use of telehealth without increasing costs to the health care system.
- **Establishing policies that narrow the digital divide** will increase accessibility for those who may have difficulty engaging in services via telehealth such as rural and low-income communities, people with disabilities, people with limited English proficiency and people with mental illness.
- **Encouraging interoperability of telehealth platforms** with other health information technology presents an opportunity to streamline processes and improve information sharing and care delivery.
- **Ensuring policies account for appropriate privacy protections** without limiting access to care can improve protections for consumers.
- **Engaging stakeholders** can be an important process for engaging subject matter experts, health providers and community members to inform telehealth policy development.

Licensure, Scope of Practice and Supervision

Consideration for Governors: policies can be used to facilitate interstate practice and the range of health care professionals for whom such practice is permitted, including required supervision.

Licensure portability

State legislators and licensing boards maintain primary authority for policies pertaining to licensure for health care professionals. Under normal conditions, and absent specific provisions extending authority, health care professionals must be licensed in the state in which they practice. During COVID-19, at least 53 states and territories took steps to temporarily enable providers to practice across state lines by expediting licensure or recognizing out of state licenses.⁷

Licensure portability enables providers to practice across state lines both in person as well as virtually. Beyond the pandemic, there are several reasons why it may be beneficial to providers and states for providers to maintain licensure in multiple states, including: providers practicing in communities near state borders, states and territories with a shortage of certain provider types, health care providers working in systems that have a multi-state presence, providers at universities seeking to maintain continuity of coverage when students are on break, multi-state employers offering health care services in house and health care providers who primarily offer services via telehealth.

Each state has their own unique applications, fees and continuing education requirements. As states consider licensure strategies to support expanded use of telehealth, there are multiple options to consider that preserve varying degree of state authority while simplifying processes for practitioners.

Interstate compacts

There are currently [five active profession-specific interstate compacts](#). Interstate compacts facilitate the process for licensure across state lines, but each compact has unique features. Some compacts provide an expedited licensure application process while others provide a compact license that is automatically recognized among participating states. There also may be variation in how states implement compacts. For example, **Indiana** implemented the Nursing Licensure Compact by requiring nurses to purchase a “compact license” in addition to their home state license, while in **Virginia**, every state-issued license is automatically a compact license if an applicant meets the requirements.^{8,9}

Modification of licensure policies to facilitate interstate mobility has the potential to increase consumer access to providers, simplify the process of licensure for providers, and decrease the cost for health care professionals if they do not need to pay for a license in each state in which they maintain active credentials. Another concept is the idea of a national license.¹⁰ A

national system would require significantly more capacity at the federal level and reduce or eliminate state oversight authority and autonomy to take actions based on unique needs.

Scope of practice

Scope of practice policies are regulatory policies that define the procedures, actions and processes permitted for a given professional based on their license. Scope of practice policies vary by state. Therefore, a given professional may be trained and permitted to perform a specific task in one state but not another. As an example, some states such as **Nevada**, allow full, independent prescriptive authority to Nurse Practitioners while other states do not.^{11§} Multiple states modified their scope of practice laws on a temporary basis to help expand the pool of health care workers who could respond to the surge of COVID-19 cases.¹² Examples of modifications include waiving supervision requirements, allowing providers such as pharmacists to offer additional services, and allowing nurse practitioners and physicians assistants to practice at the top of their license.¹³

In some instances, an activity or service may be covered by a license's scope of practice, but there are supervision requirements that limit an individual's ability to perform the function. Certain health care providers must maintain a collaborative practice agreement with a supervising physician, which impacts their practice. For instance, Advanced Practice Registered Nurses (APRNs) may require collaborative agreements with physicians practicing within a specified geographic proximity. This geographic limitation could preclude an APRN from providing a service via telehealth if the supervising provider is outside of the geographic bounds of the practice agreement.

§ The National Conference of State Legislatures and the Association of State and Territorial Health Officials created a [website](#) to track state scope of practice policies for multiple health care professions.

Strategies to Facilitate Telehealth Across State Lines

Policy	Description	Example State or Territory Action
Profession-specific interstate licensure compacts	Allows multi-state practice or expedited licensure for states that enact the compact through legislation. There are currently five active compacts.**	See Summary of Interstate Licensure Compacts
Emergency licensure compacts	Requires legislative action. During public emergencies, participating states have automatic recognition of out-of-state licenses for others in compact. Currently, 19 states and territories participate.	The Uniform Emergency Volunteer Health Practitioners Act model legislation
Telemedicine-specific licenses for out-of-state providers	State boards may issue special-purpose licenses to out-of-state providers who want to practice telemedicine only. At least 12 states offer telemedicine-specific licenses. ¹⁴	Nevada revised statute 630.261
Universal licensure during emergencies	Legislation that allows some form of universal licensure during emergencies or natural disasters for providers in good standing in their home state. At least eight states have such legislation. ¹⁵	Kansas revised statute 66-1284
Out-of-state licensure recognition	States may recognize equivalent occupational licenses from other states. This action typically comes with the requirement that the license be in good standing with no active disciplinary measures against the provider. Some states, such as Maine, may require a provider to register in the state before using their equivalent license to practice in state.	Maine revised statute title 32 §3300-D
Expedited licensure	For individuals who establish a residence or are accompanying a member of the armed services relocating to the state, expedited licensure eliminates need for duplicative training to receive a license.	Arizona revised statute 32-4302
Medical excellence zones	A state may establish zones across the state—typically communities that are rural or underserved by health providers—to allow citizens in that area to receive telemedicine services from out-of-state providers.	Virginia legislation to authorize feasibility study of medical excellence zones

** In addition to the five active compacts, there are other compacts that have been introduced but require more states to become members before they can be activated. For example, there is an [Audiology and Speech-Language Pathology Compact](#) and an [Advanced Practice Registered Nurse Compact](#).

Summary of Interstate Licensure Compacts

Type of Compact	Multi-state Compact License or Expedited Licensure	Practicing Under the Scope of Practice in State/Territory Where Patient or Provider is Located	State/Territory with Disciplinary Authority	Number of Participating States and Territories
Interstate Medical Licensure Compact ^{††}	Expedited licensure	Does not apply since medical doctors/doctors of osteopathy have full practice authority	Either the state or territory of principle licensure or member state(s) may take disciplinary action against a provider's license	30
Nurses Licensure Compact	Multi-state compact license	Subject to scope of practice in state or territory where patient is located	The Board in either participating state or territory can take action against a provider's compact license	34
Physical Therapy Licensure Compact	Expedited licensure	Subject to scope of practice in state or territory where patient is located	The Board in either participating state or territory may take disciplinary action	28
EMS Compact	Multi-state compact license	Subject to scope of practice in state or territory of principle licensure	The state or territory of principle licensure has the final authority for disciplinary action	20
PSYPACT (Telepsychology) ^{††}	Multi-state compact license	Subject to member state or territory's scope of practice	The state or territory of principle licensure has the final authority for disciplinary action	15

^{††} Supplementary information on licensure portability is available on [Provider Bridge](#), a new platform for streamlining the process of mobilizing health care providers during COVID-19 and future public health emergencies.

^{††} The [Multi-Discipline Licensure Resource Project](#) provides additional licensing information for occupational therapists, physical therapists, psychologists and social workers.

Coverage of Services Offered Via Telehealth

Consideration for Governors: Coverage of services provided via telehealth may be narrowly defined by policymakers or broadly defined to allow providers flexibility to determine when telehealth is appropriate.

Coverage parity refers to reimbursing providers for the same services offered in person that can be provided via telehealth and can also refer to the extent to which different payers must cover services provided via telehealth. Telehealth coverage policies typically address which providers may offer services, which services are covered and which modalities are covered.

Eligibility for reimbursement for providing services via telehealth

There is variation across states regarding which providers may receive reimbursement for providing services via telehealth. More narrow definitions of telehealth allow only physicians, while broader definitions include “any provider licensed in the state.”¹⁶ **New Mexico’s** statute regarding coverage for services offered via telehealth defines a health care provider as “a duly licensed hospital or other licensed facility, physician or other health care professional authorized to furnish health care services within the scope of the professional’s license.”¹⁷

According to the American Medical Association, some health plans have telehealth networks that exclude certain in-network providers.¹⁸ While these telehealth networks may be able to compete on price and may be an efficient method of delivering certain acute health services, unless they work in conjunction with the local providers, the exclusion of in-network providers could affect continuity of care.¹⁹ In addition, telehealth visits in isolation, without effective coordination between providers, could result in increased volume of services and cost. Legislation signed by **California** Governor Gavin Newsom requires that insurers include in-network providers in their telehealth networks, stating “coverage must not be limited only to services provided by select corporate telemedicine providers.”²⁰ Emergency action in **Illinois** and **Massachusetts** included similar requirements on a temporary basis during the pandemic.^{21,22}

Services offered via telehealth

There is growing recognition that telehealth is not a distinct service but instead a way to deliver care from a remote location.²³ For example, a **Connecticut** statute passed in 2018 states that “coverage must be provided for telehealth if it would be covered in-person, subject to the terms and conditions of all other covered benefits under such policy.”²⁴ As another example, **Indiana** code states that “an individual contract or a group contract must provide coverage for telemedicine services in accordance with the same clinical criteria as the individual contract or the group contract provides coverage for the same health care services delivered to an enrollee in person.”²⁵

While telehealth may serve as an appropriate vehicle for offering many services, it is not always substitute for in-person care. For example, a National Ambulatory Medical Care Survey of primary care physician-patient encounters estimated that 66 percent of visits required an in-person encounter due to their requiring a physical examination, immunization, or other procedure.²⁶ Further, though a provider may be able to deliver a service via telehealth, they may deem it more appropriate to meet in person due to factors such as patient mistrust of technology or poor digital literacy.²⁷ The National Quality Forum proposes a specific framework for measuring the quality of telehealth services, offers broad guidance on when telehealth should or should not be permitted, and provides recommendations for tailoring quality measures for telehealth services.²⁸

Modalities for services offered via telehealth

There are a wide array of telehealth and digital modalities to treat patients remotely, including synchronous live video, audio-only communications, store-and-forward, email, text, and remote patient monitoring (RPM). Some states are prescriptive regarding what modalities are permitted while others such as **California's** Medicaid program provide broad flexibility and allow providers to decide which modality is appropriate for covered services.²⁹

Historically, many states limited coverage to certain modalities, often excluding audio-only services. However, during the COVID-19 pandemic, many states temporarily expanded reimbursable modalities to include more options, which has the potential to improve access and continuity of care. Although not part of most, if any, temporary flexibilities during COVID-19, there is evidence that RPM is effective in managing chronic conditions, such as diabetes and heart disease and allows patients to receive care with fewer in-person appointments.³⁰

In addition to individuals with chronic disease, pregnant and post-partum women can benefit from access to RPM services such as blood pressure and oxygen level monitoring, digital scales and virtual breastfeeding support services.³¹ A 2020 systematic review of women who received services via telehealth during the pregnancy and postpartum period found improved obstetric outcomes such as smoking cessation, increased breastfeeding and a decrease in preeclampsia diagnoses in women with hypertension.³² To increase access to RPM programs, states may consider additional Medicaid coverage of equipment required for RPM. As of October 2020, 21 state Medicaid programs allow coverage for some RPM.³³

Distant and originating sites

Some states restrict reimbursement for telehealth to specific facility or patient settings. Patient location is frequently known as an originating site while distant site refers to the location of the provider. In traditional Medicare fee-for-services programs, CMS only allows Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) to serve as originating sites where patients receive services from another provider via telehealth; they are not allowed to serve as distant sites.³⁴ Despite flexibility to deviate from Medicare, 16

states have restrictions on the type of facility that can serve as an originating site.³⁵ Due to the current public health emergency, many states (as well as Medicare) issued emergency orders and guidance lifting restrictions, allowing additional sites such as the home, an FQHC, or an RHC to serve as an originating or distant site.³⁶ On July 6, 2020, in response to the Coronavirus Aid, Relief and Economic Security (CARES) Act legislation, CMS issued guidance which lifted certain originating and distant site restrictions during the public health emergency.³⁷

Establishing patient-provider relationships

Some states require patients to establish a relationship with a provider and have an in-person evaluation before receiving certain services provided via telehealth, while other states prohibit Medicaid or commercial plans from imposing this requirement.³⁸ Some states allow a patient and provider to establish a relationship via telehealth if the provider determines that a patient can be served at the same standard as they would be during in-person visit.³⁹ For example, a **New Jersey** statute passed in 2017 allows patients to establish care for most services remotely as long as the provider can access the patient's medical records and determine that the patient will receive treatment at the same standard as an in-person visit.⁴⁰ **Colorado's** private payer statute prohibits states from requiring patients to establish a relationship with their provider in person as a condition of telehealth coverage.⁴¹

When it comes to prescribing, some states require an in-person exam before receiving prescriptions via telehealth.⁴² And though waived during the COVID-19 pandemic, under normal circumstances, the DEA requires patients receiving medically assisted treatment (MAT) to establish care in person.⁴³ More information on some of the federal flexibilities relevant to states during the public health emergency is available in the [Federal Telehealth Policies](#) section of this brief.

Payment for Telehealth Services

Consideration for Governors: Pairing payment policies and incentives to move towards more value-based models may serve as a lever to support appropriate use of telehealth without increasing costs to the health care system.

State policies on payment for telehealth services before COVID-19

The amount providers are paid for services provided via telehealth has been a longstanding policy issue. Absent flexibilities during COVID-19, just under half of states do not require that payers reimburse providers the same amount as if the services were in person (known as payment parity) in Medicaid or the commercial market.⁴⁴ The American Telemedicine Association reports that as of 2019, 28 states have Medicaid payment parity policies and 16 have payment parity for private health insurance plans.⁴⁵ As an example, an **Arkansas** statute states that “the combined amount of reimbursement that a health benefit plan allows

for the compensation to the distant site physician and the originating site shall not be less than the total amount allowed for healthcare services provided in person.”⁴⁶ Similarly, a **Georgia** statute enacted in 2019 states that “an insurer shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis and at least at the rate that the insurer is responsible for coverage for the provision of the same service through in-person consultation or contact.”⁴⁷

Implications of fee-for-service payments for telehealth on cost

Some policymakers worry that payment parity could significantly increase the cost of health care in a fee-for service (FFS) environment, especially if services are additive rather than substitutive.⁴⁸ Convenience of telehealth could lead to an increase in its unnecessary use, raising the overall cost of health care.⁴⁹ Some argue that there are efficiencies in telehealth, making it a lower-cost service and that requiring payment parity misses an opportunity to lower costs.⁵⁰ Further, payment parity removes the opportunity for competition-based payment between providers.⁵¹ Fewer exam rooms, waiting rooms, provider time and staff are needed to execute a telehealth visit.⁵² That said, for providers new to telehealth, start-up costs, extra time helping patients adapt to new platforms and additional staff training or redeployment suggest that telehealth administration is perhaps not less expensive, at least in the short-term.⁵³

Moving beyond fee-for-service

An analysis of a survey of mostly small independent practices suggests that “[given] the significant adjustments and workflow changes required for telehealth use, value-based or population-based capitation models can better account for the expenses associated with these team-based and technology-enabled models of care.”⁵⁴ With providers in value-based payment arrangements, there is opportunity to make telehealth part of an integrated care plan with flexibility to use a wide array of platforms and many providers may already have started using telehealth well before the pandemic.⁵⁵ Further, the risk of increased cost and potential for compromised quality is mitigated for providers who are taking on financial risk and do not benefit from increased spending.⁵⁶ Therefore, as more providers participate in value-based arrangements with prospective payments, including capitated population-based payments, payment parity becomes less relevant because a lower percentage of payments are based on volume.

While short-term policy changes establishing payment parity offer a temporary revenue solution to providers otherwise relying on volume, it is not a foregone conclusion that these policies will or should stay in place. As one article suggests regarding the importance of temporary telehealth parity laws during COVID-19 and future pandemics, “[Instituting] permanent telehealth parity laws should be deferred until the issue can be further studied and the unintended consequences of such a policy are better understood.”⁵⁷



Because FFS is still a dominant payment model, payment parity remains an important consideration, especially since any transition to broader adoption of value-based payments will take time. States may choose to revert to pre-pandemic payment laws rather than further invest in what some consider “the perverse” incentives of a volume-based payment model.⁵⁸ This is especially likely if states are concerned that telehealth will increase costs disproportionate to value in FFS. Without payment parity however, providers who operate under FFS may stop or significantly scale back on providing services via telehealth, at least in the short-term, reverting to pre-pandemic usage.⁵⁹

Another option would be for states to increase flexibilities in other policy areas such as modalities or distant and originating sites specifically for providers engaging in value-based payment arrangements. This concept was proposed by the Medicare Payment Advisory Commission as an incentive for more providers to move into advanced alternative payment models.⁶⁰

Narrowing the Digital Divide

Consideration for Governors: Establishing policies that narrow the digital divide will increase accessibility for those who may have difficulty engaging in services via telehealth such as rural and low-income communities, people with disabilities, people with limited English proficiency and people with mental illness.

Access to services provided via telehealth is largely dependent on providers’ and patients’ technological infrastructure and digital literacy. Lack of broadband, high-speed internet and knowledge about how to use digital devices can create barriers to consumer access. Without strategies in place to address the needs of different populations, the expansion of telehealth has the potential to exacerbate existing disparities.

Populations that may be disproportionately affected by the digital divide include:

- **Rural residents** living in areas that lack broadband access may have difficulty using telehealth.
- **Low-income** individuals may lack the high-speed internet or data plan necessary for telehealth visits.^{61,62}
- **Individuals with disabilities** may have difficulty using the technology required for a telehealth visit.⁶³
- **Older adults** may be affected by gaps in digital literacy and need additional education and accessibility measures.
- **Individuals with limited English proficiency** may have difficulty engaging with providers without an interpreter or translation software.
- **People with serious mental illness**, particularly those in group care or those with communications anxieties or fear of surveillance, may feel uncomfortable with services provided via telehealth.^{64,65}

Low-income and rural residents' access to broadband and technology

The Federal Communications Commission (FCC) estimates that 22 percent of rural households lack broadband access, making participation in virtual video visits challenging, if not impossible.⁶⁶ Individuals and families with low incomes may face similar issues due to limited data plans and lack of Wi-Fi with sufficient speed. The federal LIFELINE program provides phones and discounted data plans to low-income consumers.⁶⁷ While this program increases access, gaps remain in the video capabilities and broadband speed required for telehealth.⁶⁸ According to the Pew Research Center, 96 percent of the population in the United States has a cellphone of some kind, but fewer than 40 percent have the video capabilities necessary to participate in a telehealth visit.⁶⁹ For an in-depth analysis of strategies to increase access to affordable broadband, see [Governor Strategies to Expand Affordable Broadband Access](#), a publication recently released by the NGA Center for Best Practices.

In 2019, the **Rhode Island** Office of Innovation convened a statewide digital equity initiative to increase access to low-cost connectivity options and educational resources. The Digital Equity Plan Overview includes key steps to reach these goals such as developing and making digital literacy courses open to the public, identifying free or low-cost Wi-Fi sources and access points, and communicating these opportunities to the public.⁷⁰ To implement these steps, the Office of Innovation collaborates with other government agencies as well as community organizations to disseminate information about the initiative and direct individuals to resources available through the program. Resources and partnerships may be leveraged to help patients access the education and infrastructure needed for telehealth visits.

Accessible technology for individuals with disabilities

Individuals with disabilities may experience barriers in accessing telehealth technology or communicating with their providers via live video and audio platforms. Many telehealth platforms do not have built-in accessibility features for patients with physical or intellectual disabilities.⁷¹ For example, individuals who are blind, deaf, or hard of hearing, or who have functional support needs may require accessibility features such as high-resolution screens, captions, sign-language interpreters and associated educational opportunities for patients and caregivers.^{72,73} To ensure that telehealth expansion does not exacerbate disparities for individuals with disabilities, providers may consider identifying potential issues and planning in advance for accommodations.

Technology and digital literacy training for older adults

According to the National Poll on Healthy Aging from the University of Michigan, 47 percent of older adults cited difficulty using technology as a key concern for using telehealth.⁷⁴ Yet, telehealth participation among older adults started to increase before the pandemic and



continues to grow.⁷⁵ Survey research from AARP indicates that older adults may need additional education in areas such as how to download telehealth apps, schedule appointments and join virtual platforms, but they are otherwise willing to use telehealth when appropriate.⁷⁶ Targeted resources could include video tutorials, frequently asked questions pages and plain-language explanations available on provider websites.⁷⁷ Furthermore, older adults may experience vision loss or hearing impairments at higher rates than others, which may make participation in telehealth more challenging.⁷⁸ Certain accessibility features like enlarged print and video images may help older adults communicate with their providers better during telehealth visits.⁷⁹

Larger provider practices may have resources to hire a telehealth coordinator who specializes in patient education and telehealth logistics or be able to use the existing workforce in new ways such as front-desk staff and community health workers to help with patient education and digital literacy training.^{80,81} States may consider taking advantage of existing programs and partnerships to offer classes and resources to older adults. For example, the **Michigan** Department of Health and Human Services leveraged an existing partnership with GetSetUp, an education technology company, to offer multiple hours of free online tutorials on using telehealth technology, videoconferencing and managing online appointments.⁸²

Translation services for populations with limited English proficiency

Under normal conditions for in-person care, individuals with limited English proficiency may have a family member or friend attend appointments to interpret for them. However, some services provided via telehealth are limited to a two-way interactive platform.⁸³ Providers should consider language access issues and how to effectively use interpreters, ensure patients understand that confidentiality exists with the interpreter, and provide written materials in multiple languages to supplement the visit.⁸⁴ Lack of dedicated resources for non-English speakers remains a critical gap in equity of care delivery.

Considerations for individuals with serious mental illness

People with serious mental illness may have heightened anxiety and privacy concerns for online treatment such as individual or group therapy sessions via telehealth. States may consider additional training and technical assistance for providers treating special populations such as those with serious mental illness. At the **Rhode Island** Department of Behavioral Healthcare, Developmental Disabilities & Hospitals (BHDDH), staff accessed the New England Telehealth Resource Center to provide twice weekly technical assistance webinars for behavioral health organizations on telehealth best practices, equipment and other considerations like safety and confidentiality shortly after the COVID crisis began and the use of telemedicine increased. BHDDH, **Rhode Island's** Executive Office of Health and Human Services and Medicaid collaborated to develop a contract with provider agencies through funding from a CMS grant that provided additional technical assistance around

telehealth. BHDDH provided the organizations with links to funding opportunities through the FCC to buy telehealth equipment, as well as funding from the Rhode Island Foundation for telehealth infrastructure, of which several providers took advantage.⁸⁵

Interoperability Across Systems

Consideration for Governors: Encouraging interoperability of telehealth platforms with other health information technology presents an opportunity to streamline processes and improve information sharing and care delivery.

It is important to consider telehealth platforms as part of a suite of broader health information systems to facilitate information sharing and a user-friendly experience for patients and providers. To fully integrate virtual care, providers offering services via telehealth need the ability to electronically access and share patient medical information, requiring use of electronic health records and interoperable information sharing platforms.⁸⁶

Access to interoperable information sharing platforms can provide access to timely information on prescriptions fills, lab results, hospitalization history and imaging information. Access to a patient's longitudinal record is important for on demand telehealth visits with providers who may not have an established relationship with the patient. Further, through integrated patient portals, patients can access their electronic health information, including the telehealth visit summary. Patients can also share their own data through digital screenings such as online questionnaires or chat functions within an app or patient portal.⁸⁷

Seamless integration of telehealth platforms into electronic health record software also can ease administrative tasks for billing, entering patient information into electronic health systems and sharing information with other providers.⁸⁸

Colorado received COVID-19 emergency funding from CMS to support purchasing equipment and advanced training for paramedics in two communities for emergency medical services (EMS) to connect to Medicaid providers through a telehealth platform.⁸⁹ An integrated bridge platform will allow interoperability between all Electronic Health Records (EHRs), Health Information Exchanges (HIEs), Health Data Exchanges, community referral programs and other applicable partner platforms. This allows Medicaid providers to serve more patients and access more patient data and information than they would through in-office visits alone. Through these projects, trained community paramedics are dispatched to an individual's home, where they provide safety screenings, fall risk screenings and referrals to community resources as needed. When appropriate, the community paramedic and a physician can connect via telehealth and work as a team to evaluate the patient's needs and determine the appropriate course of treatment, including transporting the patient to the hospital. In the short-term, the EMS programs will leverage the telehealth project to deliver care on site with at-risk populations including older adults, individuals experiencing



homelessness and lower-income populations. In the longer-term, this equipment and training has the potential to facilitate greater use of approved services provided via telehealth beyond the pandemic.⁹⁰

As another example, this year, in response to demand for better strategies to help providers monitor their patients at home, **Idaho** Health Data Exchange, a designated statewide HIE, integrated an RPM platform into the HIE⁹¹ Because the RPM technology is integrated into the HIE, providers using any EHR platform can take advantage of the functionality through the HIE portal.

Privacy Protections

Consideration for Governors: Ensuring policies account for appropriate privacy protections without limiting access to care can improve protections for consumers.

On March, 30, 2020, the Office of Civil Rights issued a notice of enforcement discretion allowing health care providers flexibility to temporarily use platforms that don't comply with the Health Insurance Portability and Accountability Act (HIPAA) for telehealth such as Facetime and Skype.⁹² This federal guidance made the use of telehealth more accessible for providers and patients.⁹³ To balance privacy and accessibility goals, certain experts have suggested revisiting HIPAA guidelines after COVID-19 and providing more flexibility regarding permissible platforms.⁹⁴

In addition to HIPAA requirements, states may have their own privacy and security requirements, many of which were also waived in relation to telehealth during COVID-19.⁹⁵ Examples of state polices that were waived or loosened include restrictions on audio-only and text, data breach reporting requirements and patient consent requirements.⁹⁶ Many states also have informed consent policies requiring written or verbal informed consent acknowledging the specific risks of services provided via telehealth.⁹⁷ During COVID-19, some states that previously required both written and verbal consent temporarily allowed patients to provide only verbal consent to receive services via telehealth.⁹⁸

Stakeholder Engagement

Consideration for Governors: Engaging stakeholders can be an important process for engaging subject matter experts, health providers and community members to inform telehealth policy development.

As states look beyond the pandemic and decide which policies should remain permanent, health officials may consider stakeholder engagement plans to get input from health care providers, plans, consumers and others.

Wisconsin launched a stakeholder engagement initiative to gather input from subject matter experts, Medicaid participants and providers regarding the permanent expansion of telehealth in the state Medicaid program post-COVID-19.⁹⁹ Through the Telehealth Expansion Project, the state held broad public engagements and issue-specific events to gather input on issues such as how to leverage telehealth for behavioral health services. The expert input will be used to make long-term decisions about the coverage policies, modalities, payment and reimbursable providers for telehealth.

The **Rhode Island** Office of the Health Insurance Commissioner (OHIC), in partnership with Rhode Island Medicaid, is convening a public stakeholder group to examine state telemedicine policies. The Telemedicine Advisory Group has been meeting since August 2020 and is considering how to improve telemedicine as a convenient, cost-effective, accessible and equitable option for delivering care in Rhode Island.¹⁰⁰ The group will provide recommendations to Governor Gina Raimondo by the end of December 2020. These recommendations will include potential revisions to emergency telemedicine policies, as well as providing input on which temporary emergency policies should or should not be carried forward on a more permanent, post-pandemic basis.¹⁰¹ Additionally, the Care Transformation Collaborative, convened by OHIC and Medicaid, is being funded to provide training and infrastructure payments to primary care practices to support their delivery of services through telemedicine modalities, enabling practices to further physical distancing measures, reduce unnecessary in-person visits and thereby mitigate the spread of COVID-19.¹⁰² These technical assistance and financial supports will ensure that practices are able to maintain the continuity and quality of care during the COVID-19 public health emergency. The project will also bring to bear technical assistance to refine existing emergency telehealth policies in the long-term to ensure they are as effective as possible in maintaining care during the current and future public health emergencies.

Federal Telehealth Policies

States have significant policy authority regarding telehealth; however, Congress and the administration maintain control over a limited but important number of policies that impact states.

Teleprescribing for medically assisted treatment for substance use disorder treatment

In 2008, Congress passed The Ryan Haight Online Pharmacy Consumer Protection Act, which prohibits dispensing controlled substances through the internet without a valid prescription.¹⁰³ The DEA has interpreted the Ryan Haight Act to require any practitioner issuing a prescription for MAT to conduct an in-person evaluation first.¹⁰⁴ This requirement was waived during the COVID-19 pandemic to facilitate continued access for individuals receiving MAT. The temporary waiver allows waived providers, to prescribe buprenorphine via telehealth, including audio-only, without first requiring an in-person visit.¹⁰⁵



National Health Service Corps

The National Health Service Corps (NHSC) is a federal program that administers scholarships and helps pay school loans for primary health care, dental and behavioral health providers.¹⁰⁶ A condition of funding is serving two years in a Health Professional Shortage Area (HPSA).¹⁰⁷

Under non-emergency circumstances:

- Both the distant and originating site must be located in a HPSA and the provider must be in an NHSC-approved facility.¹⁰⁸
- Each provider may only offer services via telehealth for up to eight hours per week.¹⁰⁹
- Services provided via telehealth must be administered through a two-way audio-visual modality such as live video.¹¹⁰

The Health Resources Services Administration under HHS temporarily waived the abovementioned requirements as a result of COVID-19 allowing providers to practice at approved alternative sites not located in a HPSA, no longer restricting maximum number of telehealth hours, and allowing providers to provide telehealth through audio-only modalities.¹¹¹

HIPAA

The Office of Civil Rights is the regulatory entity responsible for compliance with HIPAA. This includes standards for what constitutes HIPAA-compliant technology and communications for services provided via telehealth.¹¹² During COVID-19, the Office of Civil Rights issued a temporary enforcement discretion allowing use of non-HIPAA compliant platforms such as Google Chat, Facetime and Facebook chat for telehealth.¹¹³

Conclusion

Increased use of telehealth during the COVID-19 pandemic has offered a glimpse into the potential benefits of greater adoption. It has also shined a light on risks to address including the threat of exacerbating inequities and implications on cost depending on payment model. Time and additional research will reveal how the shift to telehealth impacts patients and providers.

As Governors contemplate new laws, regulations and guidance, considerations for coverage, payment, physical location of participants, interoperability, equity, and privacy will play a critical role in decision making. Stakeholders can play a critical role in informing new policy. Telehealth has the potential to increase access to care, particularly for individuals in rural and underserved areas, as well as during a time when the nation is encouraged to physically distance. It is unlikely that policymakers will uniformly codify temporary measures after COVID-19 ends, but incremental change paired with advances in payment models, technology and evidence may lead the way to improved long-term changes.

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