

GEORGIA HEALTH POLICY CENTER



TELEHEALTH NETWORK PROGRAMS: HEALTH CARE LANDSCAPE ANALYSIS

HEALTH EQUITY AND TELEHEALTH

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INTRODUCTION

The COVID-19 outbreak has changed the way we live and work across the United States. The health care industry, in particular, has made a significant pivot to providing services via telecommunications technologies, referred to as telehealth or telemedicine. Adoption of telehealth allows providers to limit in-person interaction and residents to follow social distancing guidelines and stay-at-home orders, while still ensuring access to care. Both the federal and state governments quickly responded to the pandemic emergency by issuing new policies and guidance to support the uptake of telehealth by providers and patients. These developments helped expand telehealth use in rural and other underserved areas; however, inequities persist, and some have increased due to the pandemic. This report explores the issues surrounding equity and telehealth before and during the COVID-19 pandemic and strategies for addressing equity in telehealth with examples of initiatives and health equity resources for Office for the Advancement of Telehealth (OAT) grantees.

OVERVIEW OF TELEHEALTH AND EQUITY

The Health Resources and Services Administration (HRSA) defines telehealth as “the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.”¹ This definition is established under statute of the Public Health Service Act, Section 330I 254c-14. *Telemedicine* is often used as a subset of telehealth specific to clinical diagnosis and treatment. Recently, *telehealth* has become a more common umbrella term to capture services and fields that may not have been traditionally considered telemedicine, such as provider training, continuing medical training, prevention, and health promotion, as some examples. HRSA also defines equity as the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.² As with other areas of health and health care in the United States, disparities are present in the provision of telehealth services. Not all patients have equal access to telehealth services, and not all patients receive equal benefits from telehealth services due to bias and other underlying disparities. These disparities in the utilization and quality of telehealth are most often based on race or ethnicity, income, geography, policy, technology, disability status, and language access. These areas are explored further below.

Race/Ethnicity

In the United States, African Americans are already disproportionately affected by poverty, mass incarceration, infant mortality, and limited health care access, as well as health conditions, such as heart disease, diabetes, stroke, kidney disease, respiratory disorders, and HIV.³ Nevertheless, racial disparities in telehealth use do not neatly correspond to the usual health disparities reported for minorities. Recent studies have shown that African Americans in the United States are just as likely to own a smartphone as their white counterparts, except for those making less than \$30,000 a year, in which case African Americans are more likely to own a smartphone than whites. Moreover, African Americans and Latinos are more likely to use smartphones to research health information than whites, and African Americans are more likely than whites to use telehealth services during the pandemic. Nevertheless, African American and Latino patients are still subject to the same biases and assumptions during their telehealth interactions, such as assuming they are unreliable and noncompliant, as they are during live interactions with a provider.⁴ In another study of telehealth disparities, the researchers found that being Asian was associated with fewer telehealth visits during the COVID-19 pandemic and that African Americans and Latinos were less likely than whites to use video for telehealth visits.⁵ Finally, although telehealth visits have risen in importance among tribal communities, now comprising 60% to 70% of their health care visits, barriers still remain, especially in rural and frontier communities where

¹ Health Resources and Services Administration. (2021). Telehealth Programs. <https://www.hrsa.gov/rural-health/telehealth>

² Health Resources and Services Administration. (2020). Office of Health Equity: What is Health Equity? <https://www.hrsa.gov/about/organization/bureaus/ohe/index.html>

³ Laurencin, C. T., & McClinton, A. (2020). The COVID-19 Pandemic: A Call to Action to Identify and Address Racial and Ethnic Disparities. *Journal of racial and ethnic health disparities*, 7(3), 398-402. doi:10.1007/s40615-020-00756-0

⁴ Salih, R.A., Amir, M., & Salhi, B.A. (2021). No Patient Left Behind: Considering Equitable Distribution of Telehealth. *Health Affairs Blog*, April 20, 2021. doi: 10.1377/hblog20210414.845933.

⁵ Eberly, L.A., Kallan, M.J., Julien, H.M. et al. (2020). Patient Characteristics Associated with Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. *JAMA Netw Open*, 3(12), e2031640. doi:10.1001/jamanetworkopen.2020.31640.

broadband access is scarce. In addition, many communities live in crowded households, limiting privacy and the ability to talk candidly with providers.⁶

Income

As with health care in general, those with more money have more access to telehealth. According to HRSA, nearly all Americans making over \$75,000 a year own a smartphone, compared to just 70% for those making less than \$30,000 a year.² Studies have also shown lower income is associated with less telehealth use in general during the pandemic, even though telehealth use has increased for all income levels.³ Nevertheless, other studies have shown that this increased use was mainly in counties with low rates of poverty,⁷ indicating that income disparities persist despite efforts to increase telehealth during the pandemic emergency.

Geography

Rural residents in the United States have worse health outcomes than their urban counterparts. All-cause mortality rates are higher in rural communities, especially for the five leading causes of death: heart disease, cancer, unintentional injury, lower respiratory disease, and stroke. These disparities have widened over the past decade.⁸ In addition, rural communities have higher rates of poverty, leading to lower and, in many cases, declining tax bases when compared to urban communities, making needed investments in infrastructure, such as broadband, difficult. For example, rural local governments have less money to invest in social services, public health, or clinical care than urban governments, which consistently spend more on these services.⁹ This creates a “catch 22” pattern where rural communities suffer from a disproportionate burden of disease and are in more need of government services, but governments are unable to provide services at the level needed, which leads to a higher burden of disease. Finally, rural residents often have less access to health care, especially to specialty providers, than their urban counterparts.¹⁰

The greater reliance on telehealth during the pandemic has exacerbated these already existing disparities in health care access. Even though the COVID-19 emergency has fast-tracked the provision of many health services via video and other telecommunication means, one-third of rural Americans still lack reliable high-speed internet connections, creating an access disparity during a time when more and more providers are relying on telehealth to see patients safely.¹¹

⁶ Bailey, V. (n.d.). Tribal Communities See Benefits and Challenges in Using Telehealth. mHealth Intelligence: Telehealth News. Retrieved from <https://mhealthintelligence.com/news/tribal-communities-see-benefits-and-challenges-in-using-telehealth>

⁷ Cantor, J.H., McBain, R.K., Pera, M.F., Bravata, D.M., & Whaley, C.M. (2020). Who Is (and Is Not) Receiving Telemedicine Care During the COVID-19 Pandemic. *Am J Prev Med*. doi: <https://doi.org/10.1016/j.amepre.2021.01.030>.

⁸ Garcia, M. C., Faul, M., Massetti, G., Thomas, C. C., Hong, Y., Bauer, U. E., & Lademarco, M. F. (2017). Reducing Potentially Excess Deaths from the Five Leading Causes of Death in the Rural United States. *Morbidity and mortality weekly report. Surveillance summaries (Washington, D.C. : 2002)*, 66(2), 1-7. doi:10.15585/mmwr.ss6602a1

⁹ Leider, J. P., Meit, M., McCullough, J. M., Resnick, B., Dekker, D., Alfonso, Y. N., & Bishai, D. (2020). The State of Rural Public Health: Enduring Needs in a New Decade. *American journal of public health*, e1-e8. doi:10.2105/AJPH.2020.305728

¹⁰ Summers-Gabr, N. M. (2020). Rural-urban mental health disparities in the United States during COVID-19-19. *Psychological trauma: theory, research, practice and policy*, 12(S1), S222-S224. doi:10.1037/tra0000871

¹¹ Hirko, K. A., Kerver, J. M., Ford, S., Szafranski, C., Beckett, J., Kitchen, C., & Wendling, A. L. (2020). Telehealth in Response to the COVID-19 Pandemic: Implications for Rural Health Disparities. *Journal of the American Medical Informatics Association: JAMIA*. doi:10.1093/jamia/ocaa156

Policy

Telehealth policies in the United States differ widely by jurisdiction and payer. Nationally, Medicare's rules for reimbursement set much telehealth policy. Historically, Medicare telehealth policies were designed to increase access in rural areas only. Except for the COVID-19 pandemic emergency period, originating sites for telehealth services must be located in a Health Professional Shortage Area, as defined by HRSA, or in a county outside of a metropolitan statistical area, as defined by the U.S. Census Bureau. However, Medicare has historically not allowed a patient's home to serve as a telehealth originating site, requiring the patient to travel to an originating site approved by Medicare, such as a hospital, provider's office, or Federally Qualified Health Center (FQHC). This requirement creates a disparity for those without easy access to transportation, a situation exacerbated in rural areas where there may be limited to no available public transportation.¹² However, Medicare Advantage plans are not subject to this restriction, mitigating the problem for Medicare Advantage plans that allow coverage of telehealth services without the above-described restrictions; however, not all plans take advantage of this flexibility.

Additionally, Medicare limits the types of providers that are eligible to bill for telehealth services. For example, before the COVID emergency, most allied health professionals could not bill Medicare for telehealth services, creating additional access disparities. Moreover, Medicare has not traditionally covered store and forward, direct-to-consumer, or audio-only telehealth services.¹³ However, the proposed 2022 Medicare Physician Fee Schedule, released by the Centers for Medicare and Medicaid Services (CMS) in July 2021, when finalized, will mitigate some of these disparities by removing geographic restrictions on tele-mental health services and allowing a patient's home to serve as an originating site, so long as the patient has had an in-person visit with the provider in the prior six months. The proposed fee schedule would also allow audio-only telehealth visits when used for the diagnosis, evaluation, or treatment of mental health issues in the patient's home.¹⁴

Unlike Medicare, which is exclusively a federal program, Medicaid is a joint state and federal program, with states establishing many of the policies for Medicaid in their state. Therefore, telehealth policies vary widely by state and cannot be covered thoroughly within this report on a state-by-state basis. However, there are many policies that most states have in common. Medicaid programs in all 50 states and Washington, D.C. now reimburse for some kinds of live video telehealth services; however, only 18 states reimburse for store and forward services, and only 21 states reimburse for remote patient monitoring. All state Medicaid programs impose restrictions for these services, with the most common being limitations on the types of originating sites, often prohibiting reimbursement when the patient's home is the originating site, creating the same disparity with access and transportation as Medicare, especially in rural areas. In addition, before the COVID-19 emergency, most state Medicaid programs

¹² Center for Connected Health Policy. (2021). National Policy: Telehealth and Medicare. <https://www.cchpca.org/telehealth-policy/telehealth-and-medicare>.

¹³ Freed, M, Damico, A, & Neuman, T. (2021). A Dozen Facts about Medicare Advantage in 2020. Kaiser Family Foundation. <https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/>

¹⁴ Centers for Medicare and Medicaid Services. (2021). CY 2022 Physician Fee Schedule Proposed Rule with Comment Period. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched>

were only able to pay providers for services if they were licensed in the same state, limiting providers' ability to provide telehealth services across state lines.¹⁵

Forty-three states have their own telehealth or telemedicine laws that control the reimbursement for telehealth services by private payers in their states. Most of these laws provide that any telehealth service that is also available in person be covered, but only five states provide for reimbursement parity. A recent legislative trend is for states to task professional boards, such as the board of medicine or the board of nursing, to issue practice standards for providers who use telehealth.⁵ In addition, many states are part of interstate compacts that allow out-of-state providers to render telehealth services so long as they are licensed in a state that is part of the compact. For example, 38 states, Washington, D.C., and Guam are part of an interstate medical licensure compact.¹⁶ In addition to these state laws and regulations, private insurance companies have reimbursement policies for telehealth that vary by payer, state, and policy, making generalizations about disparities difficult. However, for those with private insurance plans that do not allow telehealth visits from a patient's home or that require in-person visits for prescriptions, the transportation barriers would be similar to those with Medicare or Medicaid who face similar restrictions. Similarly, restrictions on the types of providers who can bill for telehealth services would also create similar barriers for patients.

Despite increases in health insurance coverage since passage of the Affordable Care Act (ACA) in 2010, many Americans still lack health insurance. In the first half of 2020, approximately 30 million uninsured were in the United States, resulting in a nonelderly uninsured rate of 11.1%. Uninsured rates are higher for minority populations; for example, in 2019, 12% of African Americans and 22% of Latinos were uninsured compared to only 7% of whites.¹⁷ Uninsured rates are also higher in rural areas. In 2019, 16% of residents of rural communities were uninsured. Although a decline from 23.7% before the ACA, the current uninsured rate in rural areas is still significantly higher than in urban areas (12.9%) and compared to the national average (11.1%). Moreover, the rural uninsured rate is twice as high in Medicaid nonexpansion states (21.5% vs. 11.8%), many of which are in the rural South.¹⁸ These disproportionate rates of the uninsured in rural areas exacerbate the policy-related disparities in telehealth services already mentioned by making whatever telehealth services may be available unaffordable, unless they have access to free or reduced-cost care at a local FQHC, Rural Health Clinic, or other charitable clinic.

Technology

Even if one is insured and able to receive telehealth services in their home, it takes a certain level of comfort and experience with technology to take advantage of telehealth modalities. Americans over age 65 make up 18% of the population and are most likely to need chronic disease management, but only 55-60% of these patients own a smartphone or have broadband access. And although 73% of this population does use the internet, only 60% of that group can “send an email, fill out a form, find a

¹⁵ Center for Connected Health Policy. (2020). At a Glance: State Telehealth Laws and Reimbursement Policies. Retrieved from <https://www.cchpca.org/sites/default/files/2020-10/StateTelehealthLawsandReimbursementPolicies%20FALL%202020%20.pdf>

¹⁶ Interstate Medical Licensure Compact. (2021). Participating States. <https://www.imlcc.org/participating-states/>

¹⁷ U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. (2021). Issue Brief: Trends in the U.S. Uninsured Population, 2010-2020. Retrieved from <https://aspe.hhs.gov/sites/default/files/private/pdf/265041/trends-in-the-us-uninsured.pdf>.

¹⁸ U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, Office of Health Policy. (2021). Issue Brief: Access to Affordable Care in Rural America: Current Trends and Key Challenges. Retrieved from <https://aspe.hhs.gov/sites/default/files/2021-07/rural-health-rr.pdf>.

website.” But older Americans are not the only group subject to this digital divide. According to Smith, Americans at the bottom eighth of income earners are less likely to have smartphones or broadband access and less likely to use the internet. Moreover, only 53% of this population is estimated to have digital literacy. Even when provided computer tablets for free, many patients are still not able to use telehealth because no one is available to help them download the right app and navigate through it.¹⁹ Therefore, a large portion of the population who needs telehealth access the most is least likely to have it due to technological issues.

Disability Status

People with disabilities (defined as those with limitations in activities of daily living, instrumental activities of daily living, or the ability to work, maintain a home, or attend school) make up about 20% of the U.S population but account for more than 25% of health care expenses. Those with disabilities are likely to be older, have less educational attainment, and lower income than the general population. Before the advent of telehealth, those with physical disabilities already faced significant barriers accessing health care, such as difficulty accessing buildings and public transportation, a lack of accommodation for assistive devices, and the financial burden of increased medical needs. Telehealth has been seen by many as a way to mitigate those difficulties; however, the rapid expansion of telehealth, especially during the COVID pandemic, has created some new barriers for people with disabilities.²⁰ Accessing telehealth depends on having access to telecommunications devices, such as smartphones and computers. However, according to a recent Pew Research Center study, people with disabilities are less likely to own a computer (62% vs. 81%) or a smartphone (72% vs. 88%) than those without disabilities. In addition, those with disabilities are three times as likely to say that they never access the internet compared to those without disabilities.²¹ Finally, because a disproportionate number of disabled persons live in rural areas (15% of rural residents are disabled vs. the national average of 12.6%), many may not have ready access to broadband internet capabilities.²⁰ These differences make telehealth access for people with disabilities more difficult than for the general population.

Language Access

Twenty-five million people in the United States self-report not being able to speak English “very well,” representing about 9% of the U.S. population.²² Not surprisingly, those with limited English proficiency have difficulty accessing the U.S. health system and receiving quality care. This population experiences longer hospital stays, higher rates of readmissions, and greater use of the emergency department to access care than those who are proficient in English. In addition, many lack access to preventive

¹⁹ Smith, T.M. (2021). Why achieving health equity is so hard in the telehealth age. American Medical Association. <https://www.ama-assn.org/practice-management/digital/why-achieving-health-equity-so-hard-telehealth-age>.

²⁰ Norman J, Stowers J, Verduzco-Gutierrez M. Parking Meters to Touch Screens: The Unforeseen Barriers that Expansion of Telemedicine Presents to the Disability Community. *Am J Phys Med Rehabil.* 2021 Apr 19. doi: 10.1097/PHM.0000000000001771. Epub ahead of print. PMID: 33871431.

²¹ Perrin, A. & Atske, S. (2021). Americans with disabilities less likely than those without to own some digital devices. Pew Research Center. Retrieved from <https://www.pewresearch.org/fact-tank/2021/09/10/americans-with-disabilities-less-likely-than-those-without-to-own-some-digital-devices/>

²² Craig, S., Shen, A., Wallis, K., et al. (2021). How Health Systems Can Help Address Language Barriers to Achieve Digital Health Equity. Penn Leonard Davis Institute of Health Economics, Health Equity Blog Post. Retrieved from <https://ldi.upenn.edu/our-work/research-updates/how-health-systems-can-help-address-language-barriers-to-achieve-digital-health-equity/>

services. Although studies of English language proficiency's effect on telehealth use are limited, a recent study by Rodriguez and colleagues found that those with limited English proficiency used telehealth half as much as proficient English speakers, even after controlling for other demographic variables and internet use.²³ This study was done prior to the COVID emergency and the subsequent dramatic increase in telehealth use. However, it's important to realize that, like the health care system itself, telehealth modalities in the U.S. are designed with English speakers in mind. Thus, the COVID pandemic has likely exacerbated this use disparity.²²

²³ Rodriguez, J.A., Saadi, A., Schwamm, L.H., Bates, D.W., & Samal, L. (2021). Disparities in Telehealth Use Among California Patients with Limited English Proficiency. *Health Affairs*. 40 (3): 487-495. doi: 10.1377/hlthaff.2020.00823.

COVID-19'S EFFECT ON EQUITY AND TELEHEALTH

On March 13, 2020, President Trump declared a national emergency, in accordance with the Stafford Act, for the entire United States in response to the COVID-19 crisis. Previously, on January 31, 2020, U.S. Department of Health and Human Services (HHS) Secretary Azar declared a public health emergency for the entire United States in accordance with the Public Health Services Act. Both declarations remain in effect and are expected to remain until December 31, 2021, or later. The pandemic emergency has allowed Medicare, Medicaid, and private insurance to make numerous changes to policies, some of which have already been made permanent, to make health care more accessible and available to more people. Many of these flexibilities have had a positive effect on telehealth. Nevertheless, disparities remain and will most likely increase when the emergency period ends, unless the federal government, state governments, and private insurance companies make these changes permanent. A discussion of benefits and potential challenges related to telehealth as a result of COVID-19 is described in more detail below.

Benefits

On March 17, 2020, in response to the federal government's public health emergency declaration, CMS expanded the types of services that could be provided for Medicare beneficiaries via telehealth to include regular office visits, mental health counseling, and preventive health screenings. In addition, telehealth services could be provided to beneficiaries regardless of location and setting, allowing originating sites to now include a patient's home. Providers also have been given flexibility to waive cost-sharing for telehealth services, representing those costs related to insurance that patients pay out-of-pocket like deductibles, coinsurance, and copayments. Furthermore, telehealth visits are currently reimbursed at the same rate as in-person visits during the emergency.²⁴ In addition to these changes, the CARES Act (Pub.L. 116-136), passed in March 2020, prompting CMS to make additional changes to Medicare's telehealth policies, such as expanding the types of providers who can bill for telehealth services to include allied health professionals. This includes physical and occupational therapists, increasing payments for telehealth services to equal those of in-person visits,²⁵ and providing more options and easier access for patients.

Most Medicaid programs and private health insurance plans made similar policy changes in response to the COVID-19 emergency to increase the availability and accessibility of telehealth services. All state Medicaid programs have received section 1135 emergency waivers. Section 1135 of the Social Security Act (42 U.S.C. § 1320b-5) allows the HHS secretary to waive certain requirements for health care providers in Medicaid and the Children's Health Insurance Program on a state-by-state basis during a declared national and public health emergency. These waivers have allowed state Medicaid programs to provide additional flexibilities during the COVID-19 emergency, many of which apply to telehealth. Most states now allow for out-of-state providers to provide services via telehealth to in-state Medicaid members, home health assessments to be conducted by video, and telehealth supervision of self-

²⁴ Centers for Medicare and Medicaid Services. (2020). Medicare Telemedicine Health Care Provider Fact Sheet. Retrieved from <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

²⁵ Centers for Medicare and Medicaid Services. (2020). Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic. <https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid>.

administration of medication-assisted therapy (MAT) for substance use disorders.²⁶ States have also made other changes, such as allowing homes to be originating sites, expanding the types of services that can be provided via telehealth, opening up the range of technology and platforms that can be used, and expanding the types of providers who can provide those services.²⁷ Private insurance plans have also created additional flexibilities for telehealth which vary by state, payer, and plan. The most common flexibilities include eliminating cost-sharing for telehealth visits, establishing payment parity between in-office and telehealth visits, and waiving physical exam requirements for MAT for opioid use disorders.^{28,10}

All of these changes have increased the availability of telehealth appointments and the number of Americans accessing health care services through telehealth modalities. Prior to the COVID-19 emergency, Medicare telehealth visits totaled approximately 13,000 per week. In the three months after the emergency declaration, 9 million Medicare beneficiaries (almost 700,000 per week) received services through telehealth. During this time period, approximately 22% of rural Medicare beneficiaries, and 30% of urban Medicare beneficiaries, used telehealth.²⁹ As with Medicare, the changes in Medicaid telehealth policy in all states have resulted in significant increases in the use of telehealth services by Medicaid beneficiaries. According to CMS, during the first three months of the COVID-19 emergency, more than 34.5 million services were delivered to Medicaid beneficiaries via telehealth, a 2,600% increase over the same period in 2020. Telehealth-delivered services were highest among adults age 19-64, followed by children and older adults. Service rates vary by state.³⁰ Finally, telehealth use by those privately insured has also risen dramatically. During the three months after the declaration of the COVID-19 emergency, private insurance claims for telehealth visits rose 4,000% from the previous year. Despite these policy changes and the dramatic increases in use, some insurance companies have already started rolling back these flexibilities.³¹

Challenges

Although the policy flexibilities and expansion of telehealth services that have come about as a result of the COVID-19 pandemic have addressed some inequities and have greatly expanded access to telehealth services, they do not directly address the equity issues outlined at the beginning of this report. For example, nothing in any of the policy changes for Medicare, Medicaid, or private insurance addresses the lack of broadband access in rural areas or low digital literacy among older Americans. Furthermore, policy changes that have increased access to telehealth do not really address some of the larger issues of health and health care equity that limit the use and effectiveness of telehealth. For example, in a study mentioned previously, it was found that despite large upticks in telehealth use, the greatest

²⁶ Secretary of Health and Human Services. (2021). Letter to Governors. Retrieved from <https://ccf.georgetown.edu/wp-content/uploads/2021/01/Public-Health-Emergency-Message-to-Governors.pdf>.

²⁷ Center for Connected Health Policy. (2021). COVID-19 Related State Actions. <https://www.cchpca.org/covid-19-related-state-actions>.

²⁸ Hudman, J., McDermott, D., Shanosky, N., Cox, C. (2020). How Private Insurers are Using Telehealth to Respond to the Pandemic. Peterson KFF Health System Tracker. Retrieved <https://www.healthsystemtracker.org/brief/how-private-insurers-are-using-telehealth-to-respond-to-the-pandemic/>.

²⁹ Verma, S. (2020, July 15). Early Impact of CMS Expansion Of Medicare Telehealth During COVID-19. Health Affairs Blog. <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.

³⁰ Centers for Medicare and Medicaid Services. (2020). Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19: Preliminary Medicaid & CHIP Data Snapshot, Services through June 30, 2020. Retrieved from: <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf>

³¹ Mallow, J.A., Davis, S. (2020). Health insurers are starting to roll back coverage for telehealth – even though demand is way up due to COVID 19. *The Conversation*. Retrieved from <https://theconversation.com/health-insurers-are-starting-to-roll-back-coverage-for-telehealth-even-though-demand-is-way-up-due-to-covid-19-147648>.

increases have been seen among patients in wealthier counties and metropolitan areas,⁴ locations that already had better health care access than low income and rural communities. The reality is that policy changes pertaining to telehealth can only do so much; what would really increase equity in the provision of telehealth services are larger systemic changes designed to address the inequities, such as those due to geography, race and ethnicity, income, and technology, disability, and language access that affect the entire health care system, not just one aspect of it.

Despite these shortcomings, policy flexibilities have helped increase telehealth equity; however, the policy flexibilities created due to the COVID-19 emergency are mostly temporary. Except for the changes made by CMS under the CARES Act and a few other changes, Medicare flexibilities, whether they address equity issues or not, will end with the COVID-19 emergency, which is currently predicted to last through at least the end of 2021. Similarly, all state Medicaid section 1135 emergency waivers, with their policy flexibilities, will end with the COVID-19 emergency. And, as already mentioned above, private insurance companies have already begun rolling back their policy changes. However, the COVID-19 emergency and these flexibilities have shown the effectiveness of certain policy changes for addressing equity in telehealth; therefore, several efforts are underway to make many of these changes permanent. Changes in Medicare policy post-COVID-19 will require action by Congress. CMS is currently studying telehealth flexibilities provided during the COVID-19 emergency, which will examine new opportunities for the expansion of telehealth services and coverage once the emergency period has passed. The results of that study may inform further changes to Medicare's telehealth authority by Congress.³²

Changes in Medicaid policy will require action by state legislatures and administrative agencies. States have several options available to make changes to their Medicaid programs: state plan amendments (SPAs; allow states to make changes to their Medicaid programs within the parameters of federal law), 1115 demonstration waivers (allow states to make changes to their Medicaid programs that would not normally be allowed under federal law), and changes to state laws. SPAs can be used to expand the types of services that state programs cover via telehealth to the extent that they are already an option under current federal Medicaid regulations. Other changes, such as covering out-of-state providers, may require an 1115 waiver because they would normally not be allowed under current Medicaid law and regulations. Finally, because every state Medicaid program is different and every state's telehealth laws are different, permanent changes to a state's Medicaid program may require changes to state law. CMS has already put together guidance for states for transitioning back to pre-COVID-19 Medicaid policy, which can be found [here](#) and updated [here](#). Note that this guidance is for Medicaid policy in general and not limited to telehealth.

Finally, private insurance companies may also make many of their changes permanent, but as already mentioned, some are already rolling back these changes. Changes made by private payers, if any, will vary by payer, state, and plan. Providers who expanded telehealth services in response to the COVID-19 emergency and subsequent Medicare, Medicaid, and private insurance policy changes can continue to use telehealth equipment purchased through grants and other funding during the emergency, and these will certainly help to sustain the availability of telehealth services for plan members. Providers can also continue to offer an expanded set of telehealth services, but whether they will be covered by public or

³² Centers for Medicare and Medicaid Services. (2020). Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients. Press Release. Retrieved from <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment>

private payers, may require additional policy changes. It is expected, however, that some COVID-19 related telehealth changes will revert back to pre-pandemic status when the emergency ends.

STRATEGIES FOR ADDRESSING EQUITY IN TELEHEALTH

Measurement and Data Strategies

Understanding disparities in the community is the first step to developing strategies for addressing these disparities. Telehealth providers and payers can use patient, public health, and other relevant data to inform tailored strategies for addressing health and access disparities. One of the most important strategies is to collect demographic information, such as location, race/ethnicity, income, age, etc. Data analysis can then be stratified by these categories in order to uncover any inequities by population subgroups to identify need; tailor either resources, programs, or policies to a specific population subgroup; and evaluate and measure progress in that subgroup.³³ In order to do this, providers must either employ or contract with data collection and analysis experts or train their staff in data collection and analysis techniques.³⁴ In addition to collecting quantitative information, it is also important to collect qualitative data from providers and patients in order to gain further insight into the causes and effects of disparities on telehealth use and quality. While quantitative data can provide a picture of the problem, qualitative data can reveal the reasons behind the problem and thus provide a richer picture of disparities in a community. Providers and payers can use this additional information to inform more robust and tailored strategies for addressing disparities in telehealth use and effectiveness among their patients and beneficiaries.³⁵

Provider Actions

According to HHS, providers can train staff to make telehealth accessible to all patients regardless of potential barriers by ensuring the following:

- A flexible telehealth workflow so that staff is prepared to address the needs of different communities of patients.
- Additional time for provider training on cultural competency and digital literacy.
- An inclusive patient intake process that screens for technology experience and language/communications preferences and develops a plan to address these needs prior to a patient's telehealth visit.
- Dedicated telehealth support from medical staff throughout the patient experience, including during the appointment itself, to address any challenges that arise, especially with technology or communication.³⁶

Providers can also develop a communications strategy that engages medical staff in determining how to best shepherd new patients through the telehealth process. Providers can offer materials in multiple

³³ Siegel, K. & Volk, J. (2021). Considerations for Telehealth Equity. State Health and Value Strategies. Retrieved from <https://www.shvs.org/considerations-for-telehealth-equity/>

³⁴ Institute for Healthcare Improvement. (2019). Create the Data Infrastructure to Improve Health Equity. Blog post. Retrieved from <http://www.ihl.org/communities/blogs/create-the-data-infrastructure-to-improve-health-equity>

³⁵ ETR. (2019). Qualitative Research: Helping to Move Health Equity Forward. The ETR Blog. Retrieved from <https://www.etr.org/blog/qualitative-research-helping-to-move-health-equity-forward/>

³⁶ U.S. Department of Health and Human Services. (2021). Ensuring equal access to telehealth. Retrieved from: <https://telehealth.hhs.gov/providers/increasing-telehealth-equity-and-access/>

languages and use pictures to assist those with low health literacy. Post-visit surveys can be used to measure patient satisfaction. Staff can also develop working groups to develop strategies for expanding telehealth access and communicate these strategies and their effectiveness to the larger office staff and provider networks. Providers can promote the acquisition of additional skills and experience among their staff, such as cultural competency, making connections to their local communities, working with underserved patients, and learning another language.²⁹ There are also services available via numerous companies that provide language assistance to clinical providers, specifically hospitals. Additionally, health care organizations may seek to hire medical staff who speak multiple languages or employ community health workers who represent and have connections to those underserved communities. Finally, providers can collaborate with technology companies and experts to develop strategies for overcoming the digital divide within their patient communities. For example, they can use federal funds to provide computers to low-income and marginalized communities, identify patients with low health literacy, and use community health workers to teach patients how to use a computer or smartphone.³⁷

Preparing for a Post-Pandemic World

Although the COVID-19 emergency will most likely not end until the end of 2021 or later, eventually, it will end, and many of the flexibilities that have greatly expanded the use of telehealth will also end. Medicare has already made several of its COVID-19 related telehealth changes permanent:

- Allowing diagnosis, treatment, and evaluation of mental health disorders regardless of geographic location via telehealth¹¹
- Adding more than [60 services to the Medicare telehealth list](#) and intending to cover these even after the COVID-19 emergency expires
- Allowing inpatient beneficiaries, such as nursing home residents, to access emergency department visits, therapy visits, and critical care visits via telehealth

Medicare still does not have the legal authority to pay for telehealth services in nonrural areas, but CMS announced a study of telehealth flexibilities provided during the COVID-19 emergency, which will examine new opportunities for the expansion of telehealth services and coverage once the emergency period has passed. The results of that study may inform further changes to Medicare's telehealth authority by Congress.³⁸ In addition to these changes, the Proposed 2022 Medicare Physician Fee Schedule (discussed earlier) seeks to make other permanent changes to Medicare telehealth policies (see earlier paragraph on policy in the overview section). For Medicaid and private insurance, what policies remain after the pandemic will depend on state Medicaid programs and private insurance policies, which vary widely by state, payer, and plan. (Options for state Medicaid programs are discussed in more detail in the March 2021 Landscape Analysis.)

Providers should start planning now for what they want their telehealth services to look like post-pandemic. Decisions about how to shift a telehealth program from the urgent need to provide

³⁷ Guzman, V. (2021). Design Telehealth Initiatives to Enable Health Equity Strategies. NCOA Digital Measurement Community. Retrieved from: <https://www.ncqa.org/digital-measures/resources/blogs/b501e924-611c-4097-be0b-f6dee92bb0dd/>

³⁸ Centers for Medicare and Medicaid Services. (2020). Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients. Press Release. Retrieved from <https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment>

telehealth services during the public health emergency to a longer-term telehealth strategy have implications for patients and clients served, as well as staff and partners. To support these decisions, a sustainability planning process can help clarify the importance of a telehealth program for the provider organization and for the patients served. The planning process also allows providers, leadership, and other stakeholders to make informed decisions about the future of the program. It engages partners in assessing the continuing need, evaluating the program design and impact, and identifying ways to support the program for the long term.³⁹ As providers plan for the post-pandemic world, it is important that they not only plan for the types of services they will provide via telehealth but to determine how to do that while at the same time address health disparities. To do that, providers need to examine the data, create strategies, and make decisions using an equity lens in order to maintain the equity advances brought about by the COVID-19 pandemic and, ideally, to further promote equity in the provision of telehealth services in the post-pandemic world.

Examples from the Field

Washington State Drive-In Wi-Fi Hotspots - In response to the COVID-19 pandemic, the Washington State Broadband Office created the Wi-Fi Hotspots project as a partnership between multiple state agencies, Washington State University, local libraries, and private corporations, such as Microsoft, and private foundations to create a network of over 600 public Wi-Fi hotspots. These hotspots can be used by Washingtonians without high-speed internet access to connect with health care providers via telehealth modalities. Three hundred of the hotspots are located at public libraries, many others are simply located in parking lots, and all hot spots are available regardless of how many users arrive at a location. Many allow users to access the internet either by staying in their cars or going inside a facility while maintaining social distancing and wearing a mask. In addition, the Washington State Broadband Office has partnered with the state's Public Works Board to administer \$21 million in state funding for broadband expansion in rural areas.⁴⁰

University of Arkansas for Medical Sciences High-Risk Pregnancy Program - The University of Arkansas created the IDHI High Risk Pregnancy Program (formerly known as ANGELS: Antenatal & Neonatal Guidelines, Education and Learning System) to increase access to care for pregnant women in Arkansas. This evidence-based program has increased rural women's access to care by linking patients with physicians and high-risk pregnancy services at the University of Arkansas for Medical Sciences. The program established a statewide telemedicine network for e-consultations with medical experts. Other defining components include referrals to tertiary and/or emergency care, a 24-hour call center staffed by registered nurses, follow-up home care for families of high-risk infants, and supplemental educational opportunities for providers.⁴¹

Madison Outreach and Services through Telehealth (MOST) Network - The MOST Network was formed with the primary focus of finding a way to link behavioral and mental health care services in urban communities to rural residents. The network provides counseling services to the growing Latino

³⁹ Holloman, B., Phillips-Martinez, A. (2020). *A sustainability how-to guide for providers of telehealth*. Georgia Health Policy Center. Retrieved from <https://ghpc.gsu.edu/download/a-sustainability-how-to-guide-for-providers-of-telehealth/>

⁴⁰ Washington State Department of Commerce. (2020, May 7). Press Release: Drive-in Wi-Fi hotspots launch statewide push for universal public access broadband. Retrieved from: <https://www.commerce.wa.gov/news-releases/community-programs-facilities/drive-in-wi-fi-hotspots-launch-statewide-push-for-universal-public-access-broadband/>

⁴¹ Rural Health Information Hub. Models and Innovations (updated November 2020). Retrieved from: <https://www.ruralhealthinfo.org/project-examples/681>

population of rural Brazos Valley in Texas. Counselors at Texas A&M University offer psychotherapy to patients in rural clinics via telephone and live video. Local community health workers help facilitate telehealth appointments by transporting residents to rural clinics and providing other outreach services.⁴²

Massachusetts FQHC Telehealth Consortium - Composed of 35 FQHCs, the consortium came together during the early days of the COVID-19 pandemic to ensure continuity of care in communities with disproportionate rates of COVID-19 infection. Of all the services provided, behavioral health has had the highest rates of adoption and patient satisfaction. The consortium recently received a \$3.1 million FCC Connect Care Pilot Program grant which will be used to increase provider telehealth capacity and allow the provision of additional tele-behavioral health services to 75,000 Massachusetts patients with substance use disorders. Since the beginning of the pandemic, telehealth services have been received well by FQHC consortium patients, with 93% rating their experience as good or excellent. In addition, 50% of Asians, 49% of Latinos, and 42% of African Americans have a high interest in continuing with telehealth appointments and check-ups. Nevertheless, broadband access and the availability of smartphones remain significant barriers to increased availability of telehealth services.⁴³

Delaware Telehealth Kiosk and Device Loaning Initiative - In response to the behavioral health crisis and growing digital divide, the Delaware Libraries launched a three-pronged initiative to increase access to health and social services utilizing the public library infrastructure. The initiative consists of deploying telehealth/teleservice booths in key rural libraries; disseminating hundreds of Chromebooks and Wi-Fi hotspots to public libraries statewide, so patrons can check out devices like they would a library book; and hiring a traveling community nurse to focus on treating the uninsured, underinsured, and undocumented.⁴⁴

⁴² Rural Health Information Hub. Models and Innovations (updated December 2018). Retrieved from: <https://www.ruralhealthinfo.org/project-examples/856>

⁴³ Business Wire. (2021, February 9). Massachusetts FQHC Telehealth Consortium Awarded \$3.1M FCC Grant to Increase Telemedicine Quality and Access in the Commonwealth. Retrieved from: <https://www.businesswire.com/news/home/20210209005698/en/>

⁴⁴ Delaware Libraries. Telehealth Kiosk & Device Loaning Initiative Pilot Launch (2021). Retrieved from: <https://news.delaware.gov/2021/05/12/telehealth-kiosk-device-loaning-initiative-pilot-launch/>

RESOURCES

Information, Tools, & Other Resources

HRSA Office of Health Equity: <https://www.hrsa.gov/about/organization/bureaus/ohe/index.html>

HRSA Office for the Advancement of Telehealth: <https://www.hrsa.gov/rural-health/telehealth>

Federal efforts to support and promote telehealth: <https://telehealth.hhs.gov/>

National Telehealth Policy Resource Center: <https://www.cchpca.org/>

Regional Telehealth Resource Centers (list with links): <https://www.cchpca.org/about/national-telehealth-resource-center-partners>

Telemedicine for Health Equity Toolkit: <https://www.careinnovations.org/virtualcare/virtual-care/toolkits-telemedicine-for-health-equity/>

Ensuring Equal Access to Telehealth: <https://telehealth.hhs.gov/providers/increasing-telehealth-equity-and-access/>

Coverage to Care Telehealth Resources: <https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources/telehealth-resources>

Health Equity Resources for States (includes articles on telehealth): https://www.shvs.org/health-equity/?_sft_healthtopic=telehealth-and-health-equity

Telehealth Equity Coalition: <https://www.telehealthequitycoalition.org/>

ASPE Developing Health Equity Measures - <https://aspe.hhs.gov/reports/developing-health-equity-measures>

IHI Achieving Health Equity: A Guide for Health Care Organizations – [download available here](#)

APHA Health Equity Fact Sheets, Briefs, Reports, and Infographics: <https://www.apha.org/topics-and-issues/health-equity>

Achieving Health Equity: <https://www.rwjf.org/en/library/features/achieving-health-equity.html>

Translated Telehealth Resources & Materials (compiled by the National Consortium of Telehealth Resource Centers) - <https://telehealthresourcecenter.org/resources/translated-resources/>

Webinars

Telehealth & Health Equity: Considerations for Addressing Health Disparities during the COVID-19 Pandemic: https://emergency.cdc.gov/coca/calls/2020/callinfo_091520.asp

American Telemedicine Association Webinars Archive:
https://www.americantelemed.org/resource_categories/webinars/

AMD Global Telemedicine Webinars: <https://amdtelemedicine.com/category/webinars/>

Harvard Medical School Health Disparities and COVID-19 Webinars:
<https://dicp.hms.harvard.edu/COVID-19-Resources-Health-Disparities/webinars>

Center for Connected Health Policy's "Telehealth & Medicaid: Access and Equity in Medicaid Telehealth Policy" webinar: <https://www.cchpca.org/resources/telehealth-medicare-access-and-equity-in-medicare-telehealth-policy/> (April 2021)

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