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Telehealth After COVID-19

Clarifying Policy Goals for a Way Forward

In March 2020, the coronavirus disease 2019 (COVID-19) pandemic shuttered communities and disrupted the health care delivery system. But clinicians quickly dusted off their webcams and leveraged telehealth to continue care—and keep their practices afloat—while still meeting social distancing guidelines.

Temporary, dramatic policy waivers (see box) broadened access to and payment for telehealth on an unprecedented scale. These policy changes led to skyrocketing telehealth use in spring 2020. At the time, there was a lot of talk about how telehealth's time had finally arrived, and how genies were not returning to their bottles. But that might be the wrong metaphor for telehealth use in 2020. The surge in telehealth use had ebbed somewhat by the summer months (Mehrotra et al., 2020), and it is too soon to tell whether the initial enthusiasm for virtual visits was borne of desperation (Uscher-Pines, 2020) or whether some of the newfound appreciation for telehealth can persist under the right policy conditions.

Federal Telehealth Restrictions Temporarily Changed During the Public Health Emergency and Responsible Agency or Legislation

Medicare

- Expand the types of providers that can furnish and are eligible to bill Medicare for telehealth services (Coronavirus Aid, Relief, and Economic Security [CARES] Act)
- Allow providers eligible to bill Medicare to offer services to both new and established patients inside their homes, including across state lines (Centers for Medicare & Medicaid Services [CMS])
- Allow supervision of services through audio and video communication (CMS)
- Waive requirement for the use of video technology to enable use of audio-only communication for certain Medicare services (CARES Act)
- Allow Federally Qualified Health Centers (FQHCs) and rural health clinics to provide telehealth services where patients are located, including home (CARES Act)

Controlled Substances

- Permit qualified practitioners to use a telephone or video evaluation as a basis to prescribe buprenorphine to new and existing patients (Drug Enforcement Administration [DEA])

Technology

- Waive requirement that communications platforms be Health Insurance Portability and Accountability Act (HIPAA)–compliant, as long as they are non-public facing, allowing telehealth to take place over consumer-friendly platforms (e.g., Apple’s FaceTime) (U.S. Department of Health and Human Services [HHS] Office of Civil Rights)

Cost Sharing

- Waive administrative sanctions for providers who reduce or waive cost sharing (e.g., copayment, coinsurance), for telehealth services paid for by federal or state health care programs like Medicare or Medicaid (HHS Office of the Inspector General)

In addition, most states have modified their requirements for telehealth services provided from out of state.

SOURCES: Centers for Medicare & Medicaid Services (CMS), 2020; Health Resources and Service Administration, 2020; and Pub. L. 116-136, 2020.

Many telehealth advocacy organizations, medical professional organizations, and patients support the policy shifts toward greater telehealth access that have been made during the pandemic and have been urging policy-

makers to make many of the temporary changes permanent after the pandemic ends. They argue that telehealth should continue to serve patients located in their homes or workplaces in all communities in the United States, and

that reimbursement for telehealth should be equivalent to in-person visits. Many payers and policymakers agree that telehealth has value and is a promising tool and some have signaled interest in extending certain changes. Yet they also worry about escalating costs and the potential for fraud and abuse, which were prime concerns that guided pre-pandemic policy. In fact, many of the prior restrictions on the provision of telehealth services were grounded in the assumption that telehealth's convenience would lead to overutilization and that allowing too much flexibility in reimbursable forms of telehealth would cause costs to soar.

The pandemic sidelined cost concerns, but the desire to contain telehealth costs has started to reemerge: Some payers have started to roll back cost-sharing waivers and have indicated that the days of reimbursement for audio-only visits are numbered. At least some types of telehealth are going to be wrangled back into the bottle, in lockdown like the rest of us. Though the pandemic continues, policymakers will need to make some key decisions and set priorities about telehealth policy going forward.

In this Perspective, we consider a number of possible telehealth policy goals and the evidence for each that has accumulated over the years. We end with recommendations for how policymakers might use the full range of tools at their disposal to craft targeted policies to achieve their desired goals.

The Policy Triumvirate

When considering a new policy or intervention, it is standard to explore whether it is likely to improve quality, reduce costs, improve access, or achieve some combination of these goals. A complex challenge with telehealth is that it

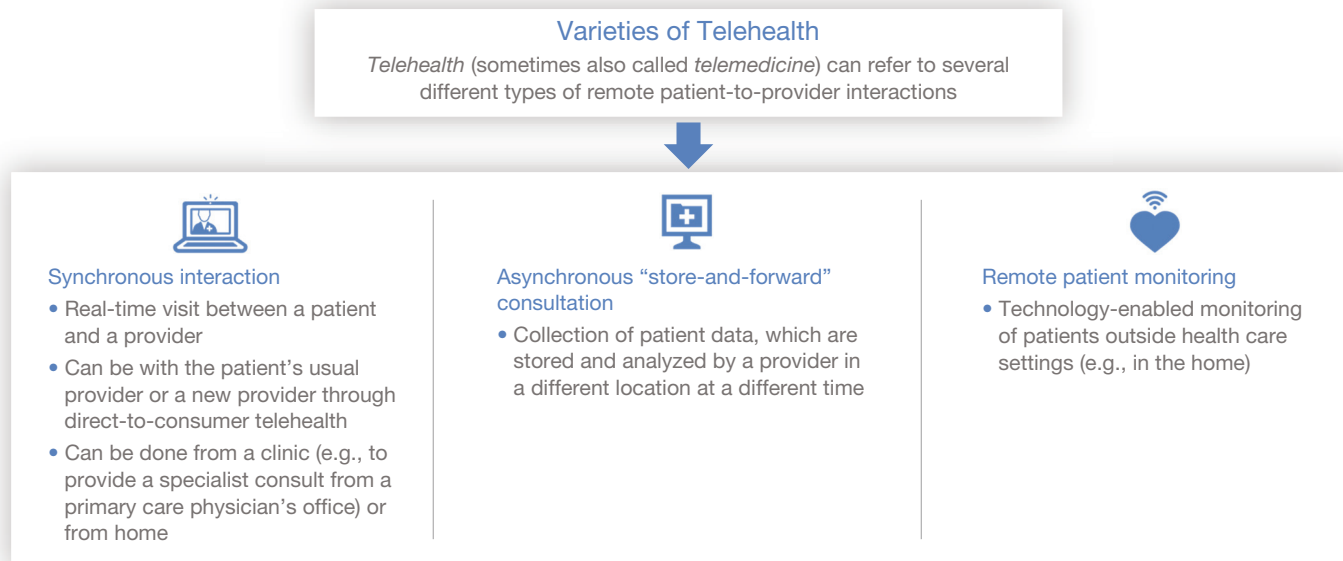
is not a monolith; telehealth can take many different forms (Figure 1) and it is far better suited to some use cases (e.g., ongoing psychotherapy for a patient with mental illness, assessment of a skin lesion to determine the potential need for biopsy) than others (e.g., prenatal care for a high-risk pregnancy, diagnosing ear pain). The most-effective policies will differentiate between different types of telehealth, different use cases, and different patient populations because impact on quality, costs, and access will vary.

Although it would be ideal to pursue all three goals with a particular telehealth service, economists typically argue that it is possible to achieve one, or possibly two, but almost never all three (Carroll, 2012). In the following sections, we consider the evidence for how well telehealth might achieve each of the three goals.

Abbreviations

ARI	acute respiratory infection
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CBO	Congressional Budget Office
CMS	Centers for Medicare & Medicaid Services
COVID-19	coronavirus disease 2019
DEA	Drug Enforcement Administration
DTC	direct-to-consumer
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
ODD	opioid use disorder
SUD	substance use disorder

FIGURE 1
Varieties of Telehealth



NOTE: Some people also consider e-consults or such programs as Project ECHO (Extension for Community Healthcare Outcomes) to be forms of telehealth, but these are typically provider-to-provider interactions that do not necessarily involve direct patient care.

Improve Care Quality

If one goal of telehealth is to improve care quality, policy-makers must take care not to transfer the current flaws of the health care system to a virtual environment. Telehealth should at least be equivalent to in-person care if not superior to it. No matter the modality of care delivery—in-person or telehealth—major struggles in maintaining high-quality health care include (1) ensuring that providers routinely follow agreed-on clinical guidelines and (2) reducing variation in quality across clinicians.

One way to compare relative quality between modalities is to examine providers' test ordering or prescribing patterns using the diagnosis code in a medical claim submitted to a payer to assess whether they reasonably follow guidelines. Various studies have looked specifically at rates of antibiotic prescribing for acute respiratory infections (ARIs), such as bronchitis or sinusitis. These rates are of high interest because inappropriate prescribing of antibiotics can lead to antibiotic resistance. Most of the studies thus far have compared in-person encounters with

direct-to-consumer (DTC) *telehealth services*, during which care is provided by clinicians with whom patients do not have an established relationship. These studies have found somewhat mixed results: In some studies, telehealth-based rates of prescribing were found to be generally equivalent to in-person visits (Eze, Mateus, and Hashiguchi, 2020; Halpren-Ruder et al., 2019; Shigekawa et al., 2018). Other studies have found correlation between overprescribing and telehealth in general (Hoffman, 2020), or higher rates of inappropriate prescribing—particularly in children (Ray et al., 2019; Uscher-Pines, Mulcahy, et al., 2016). Still others have found that telehealth providers who treat ARIs deliver less appropriate testing and require more-frequent follow-up (Shi et al., 2018).

It is unclear whether these findings represent potential challenges for telehealth in general or the challenges are more tightly linked to the DTC model for ARIs. At this time, we do not know whether the aforementioned findings would differ substantially for telehealth visits provided by a patient’s usual care team, a model that has become common since the beginning of the COVID-19 pandemic.

Clinicians have voiced a variety of concerns about the effects of substituting in-person visits for telehealth visits. Some aspects of high-quality care depend on strong patient-provider rapport, the ability to do a physical exam and quickly order tests, and clinician familiarity with a patient’s history. Furthermore, personal topics—such as asking about drug use, delivering devastating news, or counseling patients about issues not directly related to the reason for their visit (e.g., need for a flu shot)—can be harder to address during a shorter and more-transactional telehealth visit. Patients might not feel as secure in their

privacy over a video or telephone call, particularly if the provider is not the patient’s usual clinician.

Despite these concerns, telehealth visits can support the delivery of high-quality, guideline-concordant care. Mental health services, for instance, have been shown to be of equivalent quality when delivered remotely (*tele-mental health*). An Agency for Healthcare Research and Quality–funded systematic review found sufficient evidence to support the effectiveness of telehealth for psychotherapy (Totten et al., 2016). And a review of telemental health services found that providers, including advanced practice registered nurses, could effectively provide telemental health services that were as good as in-person services—and might even be preferred by some patients (Adams et al., 2018).

It might be that health care quality is a particularly good example of how telehealth can be more successful for some services and much less so for others, even within the same medical specialty. As more patients experience telehealth services with their regular providers during the pandemic, researchers might get a much better understanding of what factors tend to support—or fail to support—high-quality telehealth services.

Reduce Costs

If one goal of telehealth is to keep costs in check—or even decrease health care costs overall, by substituting office visits for potentially less expensive telehealth visits—making some COVID-19–related policy changes permanent could work against that goal. That is because more access leads to more utilization, and by extension, more spending.

In his 2014 testimony before the U.S. House of Representatives' Energy and Commerce Committee, Subcommittee on Health, Ateev Mehrotra warned that although telehealth has great potential to reduce the cost of a particular visit or episode of care, the savings could easily be trumped by overuse of services (*overutilization*) (Mehrotra, 2014). In other words, if telehealth convenience inadvertently causes people to seek care that they do not need or otherwise would not have sought, telehealth could end up exacerbating the already high cost of health care in the United States.

A 2017 study observed this in action: It appears that offering DTC telehealth services to reduce physician office

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and emergency room visits might have tapped into unmet demand for more-convenient services (Ashwood et al., 2017). Researchers examined claims data on more than 300,000 patients over three years (2011–2013) of health care use and spending on ARIs, such as bronchitis, and found that nearly 90 percent of the telehealth visits represented new utilization rather than having replaced in-person care. Spending on visits for ARIs overall increased by \$45 per telehealth user, indicating that DTC telehealth use did not lower overall spending.

The Congressional Budget Office (CBO), charged with evaluating the overall cost implications of legislative proposals, has offered several analyses of proposed telehealth legislation. In a pre-pandemic evaluation from 2019, CBO estimated that the proposed expansion of telehealth for the Medicare population (U.S. Congress, 2019)—which would waive both the originating-site (where the patient is located during the telehealth visit) and geographic restrictions for telemental health services—would add an additional 150,000 visits in 2021 and increase direct spending by \$1 billion from 2019 through 2029 (CBO, 2019). This estimate is consistent with previous CBO estimates that assume that increasing access to telehealth would increase utilization—and therefore costs—thus providing a basis for some policymakers to balk at expanding reimbursement for telehealth.

In theory, the COVID-19 pandemic could provide some evidence of the potential impact of dramatically increasing access to telehealth on health care costs. However, too much about health care delivery has changed during this time to assess the extent to which telehealth would drive new utilization in routine times. During the early months of the pandemic, it appeared that telehealth

visits substituted for in-person visits and that greater use of telehealth did not lead to escalating costs (National Committee for Quality Assurance, 2020). However, these patterns occurred in the context of widespread fear of seeking in-person care and rampant deferred care. It will be key to track telehealth utilization as patients become increasingly comfortable seeking in-person care and telehealth becomes one of several attractive options for patients to engage with clinicians.

Improve Access to Care

If one goal of telehealth is to increase access to care and interactions with clinicians, telehealth could be particularly effective, especially if it can reach patients who have slipped through the cracks of the traditional health care delivery system. Telehealth can increase convenience for those with access to in-person care and bring needed services into communities that lack in-person providers. Some populations of patients with the most to gain from telehealth include underserved patients, those who struggle with substance use disorder (SUD), and patients with chronic conditions that require close monitoring.

Underserved Populations

Low-income patients often face the greatest access challenges. They are more likely to live in health care professional shortage areas, face long wait times for care, and confront various obstacles to seeking in-person care (e.g., travel costs, limited sick leave, caregiving responsibilities). Telehealth can overcome some of the longstanding access barriers that these populations have faced.

During the COVID-19 pandemic, widespread use of telehealth by safety net organizations prevented the extreme decline in total visits that other health care organizations experienced. FQHCs in California, for example, were able to use audio-only (telephone) visits to sustain service provision at pre-pandemic levels (after a dip during initial shutdown precautions) for both primary care and behavioral health care. Furthermore, unpublished research by Uscher-Pines, Sousa, et al., 2020, showed that by offering hybrid care models that incorporated telephone, video, and in-person visits, FQHCs were able to reduce their no-show rates and decrease their wait times, in comparison with pre-pandemic levels.

It is important to note, however, that although telehealth can increase access across populations, there is a risk that its introduction can inadvertently increase disparities without careful consideration to the digital divide and patient preferences. Certain patient populations might be left behind when telehealth is implemented, including individuals without access to broadband, those who are not proficient in English, and those with limited digital literacy.

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Although the California FQHCs did not find that the transition to telehealth led to disparities in the utilization of telehealth services among safety net patients, this is not always the case, especially when access is expanded broadly rather than in a targeted manner. A different study of telehealth uptake during the pandemic found that telehealth's reach into communities with lower incomes and communities of color was limited (Whaley et al., 2020). Despite the marked increase in telehealth visits in March and April 2020, telehealth uptake in lower-income neighborhoods was one-third as large as in wealthier neighborhoods.

Substance Use Disorder

Prior to the COVID-19 pandemic, SUDs were among the few conditions that could be treated via telehealth in Medicare without originating-site and geographic restrictions. The SUPPORT Act of 2018 allowed Medicare beneficiaries to be treated for SUD in their homes (Pub. L. 115-271). Yet other barriers still limited telehealth's use: The Ryan Haight Act of 2008 (Pub. L. 110-425), for example, specifically prohibited the prescribing of controlled substances used for the treatment of opioid use disorder (OUD) via telehealth without at least one in-person visit. It appears that the SUPPORT Act alone was not enough to drive adoption of telehealth by licensed addiction treatment facilities. In 2019, only 17 percent of these facilities had telehealth capacity (Uscher-Pines et al., 2020).

Several recent trends have contributed to the growth of tele-OUD services, however. During the pandemic, the Ryan Haight requirement for an in-person visit prior to medication treatment initiation via telehealth was waived. This change allows providers to treat new patients located outside their immediate communities and to offer addi-

tional convenience to patients. Furthermore, multiple telehealth companies that operate independently of traditional brick-and-mortar clinics have emerged in the past three years to treat OUD at home. Even after the public health emergency is lifted, there likely will be a pathway for telehealth clinicians to register with the DEA to sidestep the Ryan Haight requirement because of the SUPPORT Act (Dunham and Sprankle, 2018).

Telehealth for OUD shows real promise, especially in rural communities: More than half of all rural communities in the United States have no providers who can prescribe medications for OUD. If telehealth can reach patients struggling with OUD who might not otherwise have sought care by developing strong connections with providers from the comfort of their own home, it could be a powerful tool to combat the opioid epidemic, which predates and will surely outlast the COVID-19 pandemic (Uscher-Pines, Huskamp, and Mehrotra, 2020). Telehealth for OUD care could help boost utilization of underused services and improve treatment retention by making visits more convenient and less prone to stigma. Patients seeking care for OUD often need to spend substantial amounts of time and money traveling to and attending clinic visits, and the intensity of treatment can be incompatible with work and caregiving responsibilities. Telehealth can minimize these negative effects on patients.

Increasing access to telehealth for patients with OUD should be prioritized because many patients do not receive enough care, treatment of OUD is lifesaving, and telehealth can reduce barriers to care that result in poor adherence and retention.

Chronic Conditions

Telehealth could be particularly useful for patients whose care requires many ongoing interactions with clinicians. One study found that families needing to consult pediatric subspecialists for their children's health care might be especially interested in how telemedicine can complement, rather than replace, in-person visits (Ray et al., 2017). Researchers spoke with parents and caregivers of children needing specialty pediatric care, looking for their thoughts on how best to implement telemedicine for patients and families. To their surprise, families were less interested in full telemedicine visits than in supportive care coordination activities—such as pre- or post-visit triage or follow-up questions—that can be conducted remotely and can make in-person visits with a provider go more smoothly. Families highly valued the remote use of these supportive services as a way to strengthen the quality of their medical experience overall.

Mobile health application check-ins can also support regular, in-person visits by opening lines of communication between visits. One small-scale intervention tested whether use of a clinically integrated app would improve asthma symptom management (Rudin et al., 2019). Patients were asked to use the app to complete intermittent questionnaires about their symptoms, and providers were asked to use a system that integrated information from that app into their clinical workflow. This remote monitoring form of telehealth engaged patients in their own symptom awareness, raised providers' awareness of asthma symptoms between scheduled in-person appointments, and created opportunities to address symptoms before they worsened with minimal burden on patients and providers. This intervention shows promise for being scaled to a

primary care setting and helping patients avoid urgent and emergency care.

Thinking expansively about what can constitute high-quality care delivery and carving out roles for telehealth beyond discrete visits could open up more opportunities to create hybrid care models that capitalize on the advantages of both technology and in-person interactions to connect patients to their care teams.

Additional Policy Areas

The policy goals in the triumvirate are far from the only policy goals worth considering. Recent changes in payment policy and care delivery reflect potential new goals for telehealth, such as reducing disparities in utilization and health outcomes, improving preparedness for emergencies, and increasing the provider supply.

Reduce Disparities

As noted previously, an important goal of telehealth could be to improve access for underserved populations; narrowing disparities in access and health outcomes is closely tied to that goal. It is well known that disparities in access to specific services exist for those who have certain types of insurance (e.g., Medicaid) or live in certain places (e.g., rural areas). Telehealth could be used, for example, to help increase access to specialty care among those populations that face uniquely long wait times or often defer needed care. One study of data from a Medicaid managed care plan showed that when Medicaid started offering tele dermatology services, Medicaid patients could access dermatologists at a significantly higher rate that is closer

to the level of utilization among the privately insured. Furthermore, new patients—who typically have difficulty establishing relationships with dermatologists—had the highest utilization of teledermatology (Uscher-Pines, Malsberger, et al., 2016).

However, steps must be actively taken to focus on equity and inclusiveness to achieve the goal of reducing disparities. Even as personal devices become less expensive and more ubiquitous, the digital divide thrives. A recent study that used data from 2018 showed that over one-quarter of Medicare beneficiaries lack *digital access* at home, defined as access to a computer with high-speed internet or a smartphone with a wireless data plan (Roberts and Mehrotra, 2020). Age, education, patient location, and income level play important roles in whether someone has regular access to the internet and whether they own a smartphone capable of conducting video-based calls (Silver, 2019). Providers and patients can have many types of connectivity issues that get in the way of telehealth visits: Both need a capable device, broadband access to make video calls possible (or access to a cellular network and sufficient data in mobile plans), and the digital literacy to understand how to connect remotely.

Improve Emergency Preparedness

Telehealth could be a critical tool in building and maintaining surge capacity for public health emergencies and protecting both health care workers and patients from exposure to infectious diseases. In the wake of COVID-19 shutdowns, telehealth has been able to reconnect many providers and patients. Researchers envision telehealth being used to address acute provider shortages as well, such

as when many providers are in quarantine or physically unable to get to work (Abir et al., 2020). In reflecting on the initial response to the current pandemic, researchers found that being able to successfully meet the need for a surge in staff capacity requires enhanced communication plans and coordination among hospitals, health care systems, and public health entities. Some of these relationships should be built across regions and even across states, so that as one region becomes affected, others might be able to step in to help. Many licensing and payment policies are set at the state level, so policies need to be able to evolve to handle this kind of cooperation.

Some programs, such as Project ECHO, which was first launched in 2003 at the University of New Mexico, use technology platforms to disseminate knowledge among providers. Although patient-provider interactions are not currently part of such programs, the programs could evolve and would be well positioned to use existing infrastructure to offer consultations or perhaps direct care in the event of an emergency. In situations similar to the COVID-19 pandemic, these programs can also be invaluable for disseminating emerging knowledge on a novel threat (Project Echo, undated).

Public health emergencies, of course, do not always involve a pandemic; natural disasters, such as from weather events like hurricanes or wildfires, can also create localized health emergencies. Telehealth has long been considered a valuable tool to deploy in such situations. DTC telehealth companies can also leverage their established networks, tap into providers from unaffected areas to quickly mobilize response where local networks are disrupted, and help evolve their response as the situation changes (Uscher-Pines, Fischer, and Chari, 2016).

Some DTC telemedicine companies did step forward to offer free visits to those affected by Hurricanes Harvey and Irma in 2017. Researchers studied the more than 2,000 services provided to individuals by one company in the aftermath of these two hurricanes, two-thirds of which were provided to first-time telehealth users (Uscher-Pines et al., 2018). Visits spiked within the first few days of each of the hurricanes, but most visits concerned health issues unrelated to the damage directly caused by the hurricanes: ARIs, chronic conditions, and medication needs. Less than 10 percent of the visits were injuries, back problems, or joint issues that might have been caused by the hurricane itself or resulting recovery efforts.

Although it might not make sense to regulate the use of telehealth services for the sole purpose of bolstering emergency preparedness, policymakers and providers could work together to come up with sets of temporary policies regarding telehealth to quickly enable its use in future public health emergencies.

Increase the Provider Supply

Telehealth offers numerous flexibilities for clinicians and could be deployed to increase the provider supply. This is especially important for specialties that are currently experiencing or expect to experience workforce shortages in coming years because of clinician retirement or increased demand for care. If telehealth can encourage existing providers to work more hours from home or encourage retired providers to return to practice, it can have a significant effect. For example, through the MAVEN Project and AccessDerm, retired or semiretired physicians have been paired with safety net clinics to offer services on a

part-time volunteer basis (Uscher-Pines and Rudin, 2016; Uscher-Pines, Rudin, and Mehrotra, 2017). These programs appear to be a win-win for the physicians and the clinics alike: They address physician shortages in underserved communities and give physicians meaningful opportunities to continue practicing medicine.

Recommendations

Charting a way forward with telehealth policy after the end of the COVID-19 pandemic will not be easy. Policymakers are currently under pressure from advocates to retain the temporary policies that broadened access to telehealth services. However, provider interest in telehealth remains uncertain and heavily influenced by how the policy environment evolves. Many policymakers and payers are once again becoming interested in measures that would limit utilization and contain costs.

Policymakers have numerous levers to expand telehealth access and, at the same time, control the resulting growth. Utilization-management techniques that are designed to reduce unnecessary care and control costs include reducing reimbursement for telehealth services as compared with in-person services, covering only certain services (e.g., where quality is proven and there is a need to increase utilization), narrowly defining *telehealth* (e.g., excluding audio-only visits from reimbursement), requiring preauthorization and other forms of gatekeeping, restricting who can initiate visits, limiting patient types (e.g., only permitting use of telehealth with established patients), imposing frequency limits (e.g., allowing patients to have only three telehealth visits per year), requiring in-

person visits in some frequency, and imposing greater cost-sharing for telehealth visits.

In deciding which of these techniques to apply, policymakers first need to articulate the post-pandemic policy goals of telehealth. Given that policymakers operate at many different levels and across 50 states and territories, federal leadership to codify telehealth goals would be helpful to guide goal-setting and avoid the proliferation of incongruent or even contradictory policies.

A common goal of telehealth policy in 2022 could be to increase access for only the most underserved, thereby also reducing disparities in utilization without significantly increasing costs overall. If this is the goal, payers could eliminate the geographic and originating-site requirements that make telehealth inconvenient for the underserved and also fail to acknowledge that underserved patients can live in any community; however, payers could choose to reimburse telehealth visits only for patients who have insurmountable barriers to accessing in-person services (e.g., no visits in the prior year, mobility challenges, no local provider within 50 miles). Furthermore, payers could continue to reimburse for audio-only visits because many underserved patients are not prepared for video visits, but only when there is a documented barrier to video visits (e.g., patient lives alone and does not have a device). These policies likely would keep telehealth utilization relatively low but target those most in need with precision.

Alternatively, the goal could be to set financial incentives to ensure that every patient can access high-quality

telehealth services not only from their regular providers, all of whom offer *hybrid care* models (a mix of telehealth and in-person services) but also from providers in distant communities and established telehealth companies. To work toward this goal, payers could (1) eliminate geographic and originating-site restrictions, (2) reimburse video telehealth at the same rate as in-person services to encourage universal adoption by clinicians, (3) eliminate reimbursement for audio-only telehealth because of quality concerns, (4) cover only select services shown to be equivalent in quality (e.g., behavioral health services, communication with patients with chronic illnesses), and (5) require an occasional in-person visit to offset some of the limitations of telehealth.

Policymakers will need to make many key decisions with little supporting evidence, but this is not unique to telehealth policy. No matter how the policy environment evolves, it is unlikely that telehealth advocates will get everything they are hoping for. As one stakeholder stated during the November 2020 meeting of the Medicare Payment Advisory Commission, “We will have to throw out some of the good [that telehealth offers] to protect ourselves against some of the bad” (Medicare Payment Advisory Commission, 2020). Among the myriad of potential policy goals is the desire to retain as much of the good as possible. In the case of telehealth, there is a lot of good, both in the midst of a public health emergency and beyond.

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About This Perspective

Although clinicians have experimented with telehealth for years, it did not become mainstream until the coronavirus disease 2019 pandemic curtailed in-person health care services. The rapid growth of telehealth services—spurred by temporary changes that are intended to help prioritize and maintain both access to care and adherence to social distancing guidelines—has policymakers, payers, and advocates rethinking the role that they would like telehealth to play in a post-pandemic health care system. The authors of this Perspective present considerations for how telehealth could benefit (or detract) from several policy goals. They also offer recommendations for how policymakers might use the tools at their disposal to achieve their post-pandemic goals.

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