

The Evolving Landscape of National Telehealth Policies during a Public Health Emergency: Responsiveness to Rural Needs

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TELEHEALTH DEFINED

Telehealth uses telecommunications technologies located at a distant site to enhance health care, public health, and health education delivery and support.

PURPOSE

The coronavirus pandemic precipitated significant but temporary changes in telehealth policy and the use of telehealth services to ensure access to needed health services during a public health emergency (PHE). Extending the temporary policy changes will require statutory and regulatory action. Prior to January 2020, major reports and studies, including the Bipartisan Policy Center's (BPC) recent report on rural health,¹ showed a low level of telehealth adoption and use. However, recent evidence suggests that telehealth use has significantly expanded following policy and payment changes designed to expand access to telehealth-delivered services for Medicare and Medicaid beneficiaries during the pandemic. The general population, beyond public program beneficiaries, is affected by these changes when they are also adopted by private insurance plans and when the infrastructure (including broadband capacity) supported by public programs is used in care received by others as well. This paper takes stock of current telehealth policies and assesses options for expanding the use of telehealth to support an improved rural health care system and access to care.

BACKGROUND

Advancing the Use of Telehealth Technology

Technological advances in telecommunications continue to open new horizons for telehealth as a strategy for expanding access to services for rural and other underserved populations. The RUPRI Health Panel has recognized the role of telehealth in a high performance health system:

Telehealth is a tool that complements and supports rural providers and increases access to nonlocal care for rural residents, though it should not supplant local health care resources. Policymakers should encourage telehealth expansion that improves access to care and quality of care while supporting local rural health systems.²

Face-to-face meetings between patients and clinicians have been the usual setting for most clinical services. The core strength of this form of care delivery is the relationship fostered between providers and their patients. However, telehealth services can augment the care available from local clinicians and service providers by, for example, extending access to local providers, enabling access to specialty services, supporting local providers through e-consultation, and enhancing care management through remote monitoring in patients' homes.

Despite its promise, limited rural telehealth adoption and use has led researchers and policymakers to recognize key preconditions for its effective use:

- **Infrastructure.** Broadband capacity (access and affordability) is required for effective use of the full complement of telehealth services in rural locations. In addition, providers (e.g., primary care and mental health providers, hospitals, nursing homes, public health agencies) and patients/consumers require support in acquiring and maintaining telehealth equipment and services.

- Authority. Providers require authority (licensing/scope of practice and credentialing) to engage in patient care across jurisdictional boundaries and in different settings.
- Willingness to use. Both providers (originating and distant sites) and patients must accept telehealth as a means of providing and obtaining services. Providers and patients/consumers may need assistance in learning how to use telehealth to its fullest capacity.
- Financing. Reimbursement for telehealth-delivered services must be sufficient to incentivize its use, and the administrative burden of seeking reimbursement must be reasonable.

The BPC's Rural Health Task Force (RHTF) used a process of research and collecting perspectives of stakeholders, legislators, and advocates to develop recommendations to improve rural health systems, including the expanded use of telehealth. The BPC's telehealth recommendations include the following:³

“Support expanding broadband

- Continue to prioritize connecting rural areas with broadband through anchor institutions and direct-to-home services
- Ensure effective implementation of the Broadband Deployment Accuracy and Technological Availability Act⁴

Remove restrictions preventing full use of currently available technology where broadband is inaccessible

- Expand telehealth to include non-face-to-face services
- Allow virtual visits as substitutes to office visits at lengths beyond the currently allowed 5-10 minute check-ins
- Expand asynchronous services beyond images to include written information shared by phone or through text and email

Expand list of authorized sites

- Include the home of an individual in the list of authorized originating sites for telehealth in rural areas
- Allow Rural Health Clinics and Federally Qualified Health Centers to be distance sites for telehealth services

Streamline licensure requirements

- Authorize licensed clinicians to provide inter-state services to Medicare beneficiaries

Prioritize rural-specific training curricula for health IT workforce

- Direct the Office of the National Coordinator for Health Information Technology to prioritize rural-specific training curricula for the health IT workforce”

EFFECT OF COVID-19-RELATED TELEHEALTH POLICY CHANGES ON TELEHEALTH UTILIZATION

With the onset of the pandemic in early 2020, telehealth became the logical mechanism for facilitating remote access to health services in a world where physical distancing and stay-at-home orders precluded in-person care. Using the expanded authority under the declaration of a PHE and the Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act, the U.S. Department of Health and Human Services (HHS) issued new regulations authorizing expanded use

of telehealth in clinical care. CARES Act authority, combined with standing waiver authority under Section 1135 of the Social Security Act, dramatically increased provider flexibility to use telehealth to deliver health services. Legislative and regulatory changes opened eligibility for the use of telehealth to new sites and providers, added types of services, and changed payment policy to reimburse for telehealth delivered services. Additionally, funding has been provided to support telehealth adoption and use, including funds for expanding broadband availability and grant programs for providers to obtain technology to support services in rural and underserved communities.

The regulations or statutes that authorized the policies enacted during the COVID-19 pandemic will sunset with either the end of the PHE or the end of 2020. A bill drafted by U.S. Senate Republicans includes a five-year extension of certain policies and waivers (details discussed later in this paper). Those actions reflect a broader discussion to make many of the temporary policy changes permanent. This paper contributes to that dialogue.

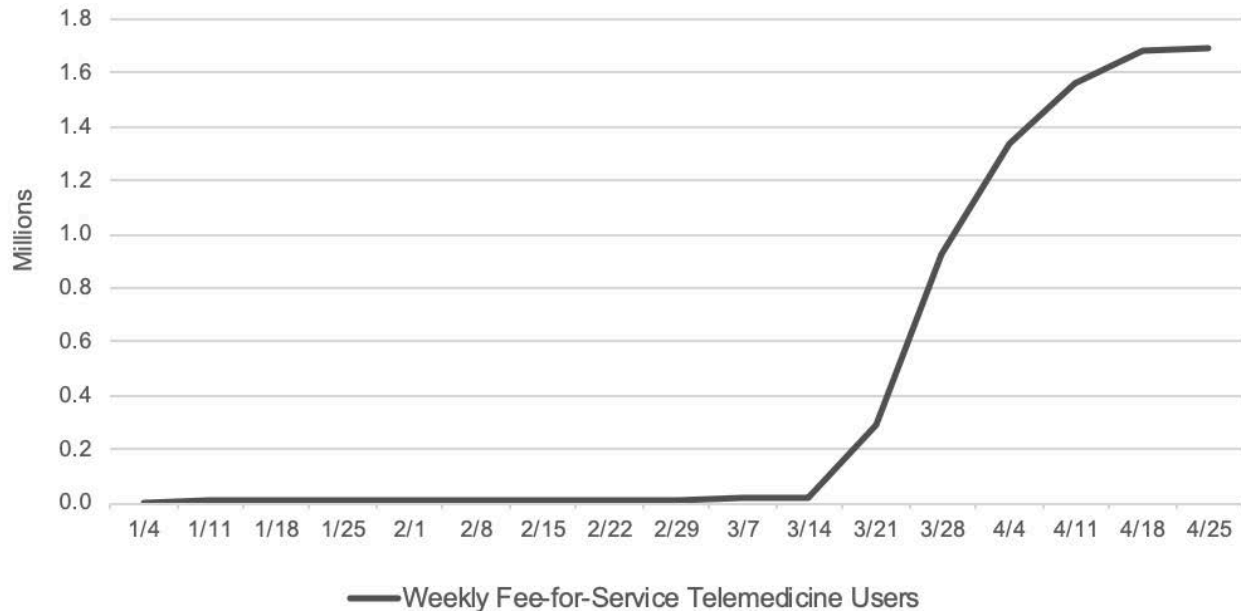
While the focus of this paper, and the BPC report, is on federal policies, it should be noted that Medicaid policies in many states have changed to parallel Medicare changes for the duration of the PHE. These changes include payment eligibility based on services provided, provider types, modalities of care, and sites of service.⁵

Changes in telehealth utilization

As shown in Figure 1, early data suggest that the PHE and related policy measures greatly expanded the use of telehealth delivered services. Prior to the implementation of the PHE, approximately 13,000 beneficiaries in fee-for-service (FFS) Medicare received telemedicine services each week. In the last week of April, nearly 1.7 million beneficiaries received telemedicine services.⁶ In total, between mid-March and mid-June, over 9 million beneficiaries received one or more telemedicine services included on the expanded Medicare telehealth list (e.g., audio-only visits, virtual check-ins, and e-visits).⁷

Evaluation and management (E/M) visits (e.g., office visits) have been the most commonly used telehealth delivered services; nearly 5.8 million beneficiaries received an E/M visit via telehealth since the PHE began.⁸ Also, nearly one-fifth (19 percent) of the 1.5 million beneficiaries who used preventive health services during this time received them via telehealth.⁹

Figure 1: Number of Medicare fee-for-service beneficiaries receiving telemedicine services per week¹⁰



Source: Internal CMS analysis of Medicare FFS claims data, March 17, 2020 through June 13, 2020 (using data processed through June 19, 2020). Note: Telemedicine is defined to include services on the Medicare telehealth list, including audio-only visits as well as virtual check-ins and e-visits.¹¹

There are notable rural-urban differences in using telehealth services, with less use among rural Medicare beneficiaries. While the percentage of FFS beneficiaries receiving telehealth services has grown for both rural and urban beneficiaries, the rate of growth has been more dramatic for urban beneficiaries, creating a gap that remains after a leveling off of initial growth. As noted in Figure 1, above, less than one percent of primary care visits were through telehealth in February. However, according to Medicare FFS claims data through April 2020, 30 percent of urban beneficiaries used telehealth services, and 22 percent of beneficiaries in rural areas did so.¹² An analysis of claims data through May 2020 that focused on delivery of primary care services found that in April 2020, 43.5 percent of all Medicare visits were through telehealth, with a slight decline in May but still at a level much higher than in February. The percentage of primary care visits via telehealth was lower in rural areas than in urban areas, peaking for rural use at 25 percent of visits and for urban use at 47 percent, and falling by June 1 to approximately 8 percent in rural areas and 20 percent in urban areas.¹³

Despite recent increases in telehealth use, studies indicate there are substantial opportunities for broadening its use, especially among hard-to-reach populations. Research suggests that demographic and socioeconomic factors may be important in explaining differences in the availability, accessibility, and use of telehealth services. According to a report by the American Hospital Association, prior to the current pandemic, many institutions offering telehealth had focused heavily on engaging young adult and middle-aged consumers because of their historic receptiveness to navigating a digital platform and an assumed possession of technical skills.¹⁴ Like many advances in health care delivery, those most readily able to access telehealth may be quite different from those for whom telehealth is most needed or for whom telehealth would render the most profound impact.¹⁵ While the pandemic is changing provider and consumer perspectives on

telehealth, evidence shows that groups facing the greatest risks currently (including older adults and those with lower incomes) are not benefiting from telehealth expansions equally.¹⁶ According to one report (based on a survey of 591 consumers done during the early months of the pandemic), only a third (36 percent) of people making less than \$25,000 reported the ability to access telehealth, while more than half (55 percent) of those making \$50,000 to \$100,000, and 70 percent of those earning \$100,000 and above reported they had access to telehealth.¹⁷ In addition, evidence suggests that a significant majority of older adults are not accessing telehealth even when they have access to it: 81 percent of consumers age 55 to 64 and 84 percent of consumers age 65 or older report not using telehealth.¹⁸

These trends are particularly relevant to the well-being of rural residents, who tend to be older and have lower incomes than do their urban counterparts.¹⁹ Like any form of health care, residence, age, gender, income, and many other individual level characteristics are likely to affect the ability to access and use telehealth. With this in mind, diminished regulatory barriers and generally expanded access to telehealth-delivered care alone are unlikely to overcome the challenges of being uninsured or under-insured or diminish the impacts of social determinants of health. Nor can they eliminate the barriers of low health care or digital literacy.²⁰ Failing to appreciate the distinct needs of rural and underserved patient populations may widen existing disparities in access and outcomes.²¹

AN ASSESSMENT OF THE CURRENT TELEHEALTH POLICY LANDSCAPE

Although significant pandemic-related changes in telehealth policy appear to have dramatically increased the use of telehealth-delivered services among both rural and urban Medicare beneficiaries, previously detailed lower use among rural beneficiaries suggests barriers to use that merit policy attention. While the federal telehealth policy changes in response to the pandemic were very significant and largely consistent with those advocated by the BPC's RHTF, some BPC recommendations remain unaddressed. In addition, many of the recent policy changes are temporary. This section details the current telehealth policy landscape, first as related specifically to the BPC-RHTF recommendations, then supplemented by highlights of other changes in telehealth policies not directly linked to BPC-RHTF recommendations.

Comparing the BPC-RHTF Recommendations and COVID-19-Related Policy Changes

This section reviews whether and how COVID-19-related telehealth policy changes have addressed recommendation made by the BPC's RHTF. Table 1 presents the BPC's recommendations, pre-pandemic federal telehealth policies, and legislative and regulatory policies enacted in response to the pandemic (and their expiration dates). Below we review the BPC's five general recommendations (the table lists the nine more specific recommendations).

Support expanding broadband and collect accurate broadband data

While broadband connectivity has been expanding in recent years, rural disparities in access to services remain. The BPC cited the 2019 Federal Communications Commission's (FCC) report stating that 26 percent of rural Americans lacked access, as well as 32 percent of Americans on tribal land. In contrast, 1.7 percent of urban Americans lacked access.²² The BPC recommended increased federal appropriations to establish more access through anchor institutions, including health centers, and extending access to rural homes. This could be done through programs within

the FCC, the U.S. Department of Agriculture (USDA), and other programs supported by federal agencies, including the Health Resources and Services Administration (HRSA). The BPC also recommended more detailed data collection, consistent with the provisions of the Broadband Deployment Accuracy and Technological Availability Act of 2020. Improved data would enable better targeting of capital expenditures to places of highest need.

Telehealth Policies in January 2020. As described, several federal agencies have authority to spend appropriated dollars to support expanded access to broadband services. At issue is the adequacy of those appropriations. The BPC estimated the costs of their recommendations to be between \$53 billion and \$80 billion for both anchor site and residential access.

Policies since March 2020. Federal responses to the coronavirus pandemic (in four legislative packages, culminating in the CARES Act in March 2020) added appropriations for FY 2020:

- FCC: \$200 million to help provide services to patients at their homes or mobile locations²³
- HRSA: \$275 million to support rural Critical Access Hospitals, rural tribal health and telehealth programs, and poison control centers
- HRSA: \$2 billion appropriated for Community Health Centers, for multiple purposes, a fourth of which is to enhance telemedicine through actions related to infrastructure and to support transitions to increase care through telehealth
- USDA: \$25 million for rural development to support the Distance Learning and Telemedicine Program, and \$100 million to the ReConnect program to help ensure rural American have access to broadband
- Indian Health Services: \$1.032 billion includes new investments for telehealth services

Further Action Needed: These appropriations suggest there is considerable potential for increased federal investments to expand access to broadband capacity, especially in rural and underserved areas. While not all telehealth use requires broadband capacity, the full potential of telehealth for rural residents and providers will not be realized until broadband is as accessible in rural areas as it is in urban areas.

Remove barriers preventing full use of available technology

Opportunities abound for telehealth to enhance patient care through applications of technology in place of in-person patient-provider interactions. The BPC specifically recommends expanding the use of asynchronous telemedicine services for purposes such as specialist consultation and reviewing images. Beyond those uses, the BPC also recommends using asynchronous services that include sharing written information by phone, through text, and email communications. Further, the BPC recommends “allowing virtual visits as substitutes to office visits at lengths beyond the currently allowed 5-to-10 minute check-ins.”²⁴

Telehealth Policies in January 2020. New virtual care payment codes were created by Centers for Medicare & Medicaid Services (CMS) in the final 2019 physician fee schedule to allow billing for reviewing previously recorded images.²⁵ Medicare Advantage plans and Accountable Care Organizations are allowed to include expenses associated with remote patient monitoring in benchmarks that determine capitation and shared savings.

Policies since March 2020. During the PHE, virtual visits can include evaluation and management visits, mental health counseling, and preventive health screening. Also, providers may deliver

certain services using audio-only technology due to a CMS waiver of the requirement for video technology, for a specified subset of services.

Further action needed. Uses of technology, including through means not requiring broadband connectivity, are worthy of further demonstration through waiver authority during the remainder of the PHE and beyond. As recommended by the BPC, these include sharing information as an element of patient care, including through text and email.

Expanding the list of authorized sites of service

The evolution of Medicare policies has focused on two fundamental decisions—what services are eligible for payment through telehealth and, for purposes of payment, which providers (including institutions) can be originating and distant telehealth sites. Regulations for both have been restrictive. With regard to eligible sites, the BPC recommends that sites be expanded to include patient homes as originating sites and Rural Health Clinics (RHCs) as distant sites. The latter would be accomplished with enactment of the Rural Health Clinics Modernization Act of 2019 and the CONNECT for Health Act of 2019.

Telehealth Policies in January 2020. Originating sites had to be in a clinic setting, including RHCs and Federally Qualified Health Centers (FQHCs), but not patient homes. RHCs and FQHCs were not eligible to be distant sites.

Policies since March 2020. Using waiver authority granted by the CARES Act during the PHE, CMS has waived restrictions on what sites can be eligible as originating sites, enabling patients to receive telehealth-enabled services in their homes. The CARES Act instructs the Secretary of HHS to pay for telehealth services furnished by an FQHC or an RHC, making them eligible to be distant sites.

Further action needed. The policies in place during the PHE should be made permanent.

Streamlining licensure requirements

State licensure requirements that care delivered to patients in a state must be provided by clinicians licensed by that state have been a constraint on the availability and use of telehealth services. Although interstate licensure compacts have lessened or removed this barrier in many states, not all states participate in such compacts. The BPC recommended that Congress pass legislation introduced in the 113th Congress that would authorize licensed providers in one state to provide services to Medicare beneficiaries in another state for purposes of providing telehealth services in rural areas or Health Professional Shortage Areas.

Telehealth Policies in January 2020. The Interstate Medical Licensure Compact (IMLC) includes 29 states, the District of Columbia, and the Territory of Guam Organizations, providing an opportunity for physicians to hold an unrestricted medical license in one state that serves as the “State of Principal License (SPL).” The SPL shares all the information used for its license with additional states, which expedites the licensure process in those states.²⁶ While helpful, the IMLC is not a national policy and still requires separate licensure in each state. Providing telehealth services outside of the clinician’s home state occurs because the provider is licensed in multiple states, or through a consultation process with the local direct provider with or without a retainer fee but not involving patient billing by the consulting clinician. The Veterans Health Administration (VHA)

implemented a model of providing patient care from out-of-state sites. In that case, licensure to serve that particular population is in the VHA national system, not through individual states.

Policies since March 2020. CMS temporarily waived a Medicare and Medicaid requirement that clinicians be licensed in the state where service is provided. However, state requirements still apply.²⁷

Further action needed. Absent more widespread state participation in the existing IMLC, or alternatives for interstate licensure, the BPC recommendation remains a next step.

Prioritizing rural-specific training curricula in health information technology (HIT)

BPC discussion related to HIT focused on use of electronic health records and IT training. While there has been a great deal of progress in expanding HIT in clinical settings, rural providers continue to lag in taking full advantage of advances in using technology to improve patient care. This includes use of electronic health records as well as other digital technology such as telehealth services. Some of the rural lag is due to deficits in trained personnel, either full-time employees dedicated to HIT or those whose positions include HIT responsibilities in addition to others. Given that reality, the BPC recommends the Secretary of HHS “direct the Office of the National Coordinator (ONC) for Health Information Technology to prioritize rural-specific training curricula.”²⁸

Policies as of January 2020. In implementing the American Recovery and Reinvestment Act of 2009 the ONC used \$120 million to support more HIT-focused training. A grant program in workforce training for health care professionals continues; the most recent cycle included \$6.4 million.²⁹ The Federal Office of Rural Health Policy (FORHP) has engaged with ONC to develop rural-focused curricula targeting full-time health care workers. The BPC recommendation is to further revise a curriculum funded by FORHP in 2013.

Policies since March 2020. No specific appropriations were identified.

Further action needed. Using information technology may help clinicians and staff adjust to the changes inherent in adopting telehealth as a delivery modality. Clinical workflow may need to be modified, facilitated by IT. In much of rural America, independent physician practices remain viable, and in other places, small integrated groups are being sustained. Those practices will need assistance, including implementing the curricula developed by FORHP and ONC.

Actions beyond the BPC-RHTF recommendations

Several other actions have been taken during the pandemic that create possibilities for expanded use of telehealth. Like those discussed above pertaining to the BPC recommendations, these policies are in place until the end of the PHE and, unless extended through regulatory authority or legislation, will expire. These include:

- All health care professionals, including therapists, speech language pathologists, and others may deliver and bill for services delivered through telehealth. This is a waiver under CARES Act authority of a statutory limitation to physicians and a limited set of nonphysician practitioners. This action matches up with the BPC recommendation that regulatory and statutory barriers be removed that prevent nonphysician providers from practicing at the top of their license.

- Hospice and home health requirements for face-to-face visits for recertification and services are waived per Section 3706 of the CARES Act.
- Direct supervision by physicians can be provided using interactive audio and video technology. This is a CMS regulatory change that expires with the end of the PHE.
- Services eligible for Medicare payment were expanded by 135 additional services, with authority to add more to the list through a subregulatory process (does not require notice-and-comment rulemaking). The regulatory process could be used to make the changes permanent.
- Previous rules limiting remote patient monitoring (RPM) to established patients have been expanded to allowed for new patients and for acute conditions. Regulatory authority could be used to extend these changes beyond the PHE.
- The landscape in telehealth policy changed considerably since March 1, 2020, after the rise in COVID-19 pandemic cases. Rapid actions have been taken to support use of technology to connect patients to health care providers and services, through both regulation and legislation.

Table 1: BPC Rural Telehealth Recommendations & Federal Policy Response to COVID-19: Summarizing Current Progress pertaining to Rural Telehealth

Related BPC Recommendations	Baseline Federal Telehealth Policies Active prior to January 2020	Federal Policy Changes in Response to COVID-19 since January 2020
Support Expanding Broadband		
<p>Continue to prioritize connecting rural areas with broadband through anchor institutions and direct-to-home services³⁰</p>	<ul style="list-style-type: none"> □ Increasing investments in rural infrastructure was a key recommendation of the USDA task force’s report in January 2018 (Report to the President of the United States from the Task Force on Agriculture and Rural Prosperity) □ In March 2018, Congress provided \$600 million to the USDA to expand broadband infrastructure and services in rural America.³¹ □ In May 2019, the Appropriations Committee released the Fiscal Year 2020 Agriculture-Rural Development-FDA Funding Bill, which invests over \$680 million in the expansion of broadband service to provide economic development opportunities and improved education and health care services.³² □ In December 2019, the U.S. Secretary of Agriculture announced the availability of a second round of \$550 million in USDA Reconnect Pilot Program funding appropriated by Congress. (The first round of funding was announced December 2018).³³ 	<ul style="list-style-type: none"> □ The FCC’s COVID-19 Telehealth Program provided \$200 million in funding as part of the CARES Act to help health care providers provide connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic.³⁴ □ HRSA awarded over \$2 billion in support of HRSA-funded health centers and Health Center Program look-alikes from March to July of 2020, \$12.9 million of which supported training and technical assistance to enhance health centers’ COVID-19 response. □ In July 2020, the draft Fiscal Year 2021 spending bill for the Agriculture Department proposed \$1.1 billion for investment in rural broadband (a \$435 million increase relative to what was appropriated in 2020).³⁵
<p>Ensure effective implementation of the Broadband Deployment Accuracy and Technological Availability Act³⁶</p>	<ul style="list-style-type: none"> □ The Broadband Deployment Accuracy and Technological Availability Act was signed into law in 2020. 	NONE
Remove Restrictions Preventing Full Use of Currently Available Technology where Broadband is Inaccessible		

Related BPC Recommendations	Baseline Federal Telehealth Policies Active prior to January 2020	Federal Policy Changes in Response to COVID-19 since January 2020
<p>Expand telehealth services to include non-face-to-face services to allow for full utilization of technology in areas without broadband access³⁷</p>	<p><input type="checkbox"/> Pre-COVID-19, Medicare could generally only pay clinicians for telehealth services involving an interactive audio and video telecommunications system that permits real-time communication.³⁸</p>	<p><input type="checkbox"/> In an <u>interim final rule</u> released April 30, 2020, CMS increased the number of services for which audio-only telephone visits may be used and increased payments for audio-only telephone visits between Medicare beneficiaries and their physicians to match payments for similar office and outpatient visits.³⁹</p> <p><input type="checkbox"/> CMS recognizes audio-only technology for payment for behavioral health services.⁴⁰</p>
<p>Allow virtual visits as substitutes to office visits at lengths beyond the currently allowed 5- to 10-minute check-ins to allow for full utilization of technology⁴¹</p>	<p><input type="checkbox"/> Pre-COVID-19, established patients could receive Virtual Check-ins (a 5-10 minute check-in) with a practitioner via telephone or other telecommunications device to decide whether an office visit or other service was necessary; and/or a remote evaluation using images and/or recorded video submitted by the established patient) as a form of Medicare Telemedicine Services under HCPCS code G2012 and code G2010.⁴²</p>	<p><input type="checkbox"/> Under the Section 1135 waiver expansion, the specific set of services beneficiaries can get include evaluation and management visits (common office visits), mental health counseling, and preventive health screenings.</p>
Expand List of Authorized Sites		
<p>Include the home of an individual in the list of authorized originating sites for telehealth in rural areas⁴³</p>	<p><input type="checkbox"/> Pre-COVID-19, Medicare could only pay clinicians for telehealth services, such as routine visits, in certain circumstances. For example, the beneficiary must live in a rural area and travel to a local medical facility to get telehealth services.⁴⁴</p>	<p><input type="checkbox"/> Under the 1135 Telehealth Waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence starting March 6, 2020.⁴⁵</p> <p><input type="checkbox"/> Under this Section 1135 waiver expansion, beneficiaries can get telehealth services in any health care facility including a physician's office, hospital, nursing home or rural health clinic, as well as in their home.⁴⁶</p>
<p>Allow Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) to be serve as distant sites for telehealth services⁴⁷</p>	<p><input type="checkbox"/> This measure was included in the proposed H.R.2788 Rural Health Clinic Modernization Act of 2019 and in the proposed S.2741 Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019.⁴⁸</p>	<p><input type="checkbox"/> Section 3704 of the CARES Act authorized RHCs and FQHCs to furnish distant site telehealth services to Medicare beneficiaries during the Public Health Emergency.⁴⁹</p>
Streamline Licensure Requirements		
<p>Authorize licensed clinicians to provide interstate services to Medicare beneficiaries⁵⁰</p>	<p>NONE by federal entities</p>	<p><input type="checkbox"/> The 1135 waiver suspended the Medicare and Medicaid requirement that physicians and other providers hold a license in the state in which they provide care if they hold an equivalent license in another state.</p>
Prioritize Rural-Specific Training Curricula for the Health IT Workforce		
<p>Direct the Office of the National Coordinator for Health Information Technology to prioritize rural-specific training curricula for the health IT workforce</p>	<p><input type="checkbox"/> The Federal Office of Rural Health Policy (FORHP) funded 15 grantees for the Rural Health Information Technology Workforce Program in 2013-2016. In addition to establishing new health IT training programs, the program was designed to ensure that others could build on the grantees' <u>curriculum resources</u>, helping to seed additional programs at rural-serving community colleges.⁵¹</p>	<p>NONE by the Office of the National Coordinator for Health Information Technology</p> <p>NONE by other federal entities</p>

Related BPC Recommendations	Baseline Federal Telehealth Policies Active prior to January 2020	Federal Policy Changes in Response to COVID-19 since January 2020
	<input type="checkbox"/> (FORHP Rural HIT Workforce Program grantees developed an inventory of curriculum resources, including detailed course descriptions and training materials at the close of the program in 2016. ⁵²)	
Expand access to treatment for opioid use disorder by allowing waived providers to offer services through telemedicine	<input type="checkbox"/> None specific to this recommendation	<input type="checkbox"/> The Drug Enforcement Administration with the Substance Abuse and Mental Health Services Administration established a PHE exemption of the in-person requirement to provide services.

DISCUSSION

The RUPRI Health Panel has established a framework to analyze the contributions of public policies to a broader goal of creating delivery systems in rural places that best serve rural people, sustaining networks of essential local providers, and doing so to benefit the community. We established goals across six pillars. Effectively using telehealth services could contribute to achieving those goals of a high-performance rural health system. *Access* would be improved by making services available to patients where they live, bringing clinical care from distant sites to originating sites in their communities, and making personal services to monitor chronic conditions available in their homes. *Affordability* would be enhanced if telehealth services supplement primary care services in rural communities. This can happen in two ways, both of which are manifest in expanded telehealth use during the PHE. First, local primary care providers can use telehealth to reach more local residents more efficiently through e-consults, and primary care teams can manage patient needs. Second, working with distant sites, primary care providers can more effectively manage patient needs across the continuum. *Community-based design* of health systems is facilitated by better communications between local providers and distant providers, creating more flexibility in how local resources are managed. *High quality* services are enhanced through provider education as well as patient monitoring that engages appropriate expertise. The local system becomes even more *patient-centered* because patients take more control of how they receive services.

Current expansions in use of telehealth services create opportunities to test the assumptions just described for their utility in improved patient care. Telehealth creates opportunities to improve care coordination and ensure comprehensive, integrated care. The benefit to underserved populations, including those in rural areas deserves attention as the system continues to evolve. Implementation should be informed by studies of patient utilization of new services, including understanding reasons for comparatively less use among the traditionally underserved. Policies should address inhibitors, including spread of broadband capacity, affordability of technology to systems and consumers, and knowledge barriers to understanding contributions to patient care and how to navigate new applications of the technology.

Work remains to facilitate further use of telehealth services, but the changes during the PHE have reset the landscape. There are opportunities to solidify gains being made, and to consider further changes.

CONSIDERATIONS

Pressure is mounting to make many of the COVID-related telehealth policy changes permanent. Stakeholders, including the American Hospital Association and the American Telemedicine Association, are advocating continuation of telehealth policy changes. Surveys of both providers and patients show support for continuation of these policies. Members of Congress in both political parties have introduced legislation to make many of the changes permanent (the specific changes vary across bills). The proposed rule for physician payment in CY 2021, printed in the *Federal Register* on August 4, 2020, extends several telehealth provisions. The momentum to build on what has been done during the pandemic creates an opportunity to advance the contribution of telehealth to advancing the elements of a high performing rural health system.

Future Directions for Telehealth Policy

Extended research into the effects of the COVID-related telehealth policy changes on access, quality of services, and costs will be critical to understand the future effective utilization of telehealth in rural places. As is often the case in evaluating new programs and even incremental change, ensuring a focus on impacts for rural residents will be challenging due to a natural focus on the larger number and more rapid growth of telehealth visits happening in urban areas.

It is important to understand the full impact of the changes in telehealth on the availability of, and access to, health care services in rural places. If early trends continue—showing lower take up of telehealth in rural areas as new services became eligible—it will be important to understand the reasons for that rural differential, identifying any remaining inhibitors for either providers or patients. Providers include physician clinics, rural health clinics, hospitals, and hospital-based health systems. Patient use studies are needed for telehealth use in all settings, including homes and clinics.

Further considerations of telehealth policies, and the impact on rural people and providers, are delineated below using the preconditions for optimum use described earlier in this paper.

- *Infrastructure:* Funding for broadband has increased since the onset of the pandemic, and both political parties favor further investments. As presented by the BPC, considerable additional investment is needed. Grant funds have helped FQHCs and RHCs expand their investments in equipment. Continued investment is needed. Grant programs from the FCC and HHS have provided help, particularly through the telehealth resource centers. Continued funding is needed for those efforts, as well as for programs to support equipment upgrades.
- *Authority:* The BPC's recommendations were followed in expanding eligible delivery sites, and additional changes expanded the types of providers that may provide and bill for telehealth services.
- *Willingness to use:* The increased use of telehealth during the pandemic must be understood. With telehealth use up considerably, both providers and patients are demonstrating willingness to use, but two factors must be considered in studies of that use. First, is the use only because of the pandemic and its effect on the desirability of clinic visits? Second, are the uses of telehealth evident in the claims data the types of services that promote greater access to care and higher quality of care through more effective care management? Expanded opportunities to use telehealth services create more need for provider education

(clinicians and staff). Technical assistance available through telehealth resource centers will be instrumental; increased funding for those centers during the pandemic could be continued into the next fiscal year. Patient education should be another point of emphasis.

- *Financing*: Medicare reimbursement is available to more providers, for more services, and in more settings during the PHE. Assessments of the costs and benefits of those expansions to the Medicare program are needed. Both public programs and private insurance carriers will need to know how to set reasonable payment for telehealth services that are now substitutes for clinic visits. The payments should create incentives to use telehealth technology, which will in turn improve access to affordable services. Payment for telehealth in rural settings may be a totally new expense (not replacing in-person visits but instead opening up new access). Assessing the impact will need to balance a new expenditure with the benefits of increased use of appropriate services.

In summary, policy considerations in 2020 begin with extending the flexibility granted by legislation and waivers during the pandemic. Doing so, however, is merely a foundation for continuing to explore appropriate uses of telehealth. In a rural context, telehealth continues to be an important tool to augment delivery systems by increasing access to services for residents in communities where they live.

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