American Heart Association.

POLICY POSITION STATEMENT
June 2020

Expanding Access to Care Through Telehealth

Introduction

The outbreak of COVID-19 has put a strain on the healthcare industry and laid bare significant gaps in access to quality care in the United States. Issues such as large populations of uninsured and underinsured, primary and specialty care shortages, hospital closures, and the disproportionate impact of chronic disease on minority ethnic and racial populations have been magnified exponentially by the outbreak. Additionally, many states and local communities have implemented stay-at-home edicts, thereby further restricting patients' access to traditional healthcare. The crisis has forced healthcare systems and regulatory bodies to turn to turn to telehealth to provide healthcare. Telehealth (see glossary in Appendix A for definition) has enabled patients, healthcare providers and health systems to communicate through virtual channels in in-patient, ambulatory, and non-healthcare environments.

As such, in March 2020 the federal government temporarily lifted restrictions on Medicare reimbursement for telehealth. Various state governments did the same with Medicaid. The new measures have facilitated significant changes (See Table 1 in Appendix B) in the way healthcare is provided, enabling patients to access healthcare in the privacy of their own residency regardless of their geographical location. However, while telehealth has the potential to make quality health care accessible to more people, the increased emphasis on it amid the COVID-19 pandemic has exposed additional inequities in the United States healthcare system that have not been previously addressed. Therefore, the American Heart Association (AHA) recognizes the potential impact of telehealth on access to quality care and supports policies that ensure patients and healthcare providers are adequately reimbursed for it and have access to its benefits when it is clinically appropriate.

A New Paradigm for Equitably Expanding Access to Care

In recent years, the AHA published statements on telehealth, rural health, and expanding access to adequate and affordable care, all of which outline a set of principles that collectively point to the AHA's vision of enhancing population wellness by addressing all sources of inequity, including race and ethnicity, gender, sexual orientation, and socioeconomics (see Figure 1 for a visualization of how these statements synthetically lead to enhancing population wellness). They also underscore the AHA's mission to be a relentless force for a world of longer, healthier lives.

In early 2020, the AHA released its 2020 Statement of Principles for Adequate, Accessible and Affordable Health Care.[1] It was written in the context of advances in coverage and care that have occurred over the previous 12 years and the rapidly changing landscape of healthcare delivery systems. It denoted that every person should receive high-quality, affordable, and patient-centered healthcare, regardless of race and ethnicity, gender, sexual orientation, and socioeconomic status. This was also emphasized recently in the AHA's Presidential Advisory on Rural Health, which called for a series of economic and infrastructural measures to address the pervasive disparities that are hampering access to quality healthcare in rural populations.[2, 3]

The COVID-19 pandemic shifted the paradigm, however, when it comes to ensuring all patients have access to adequate and affordable care. Telehealth filled the void and quickly shifted from a previously slow adoption path to a record pace of uptake. Telehealth use for primary care among Medicare beneficiaries increased dramatically over the first couple of months of the pandemic.[4] Nearly half of Medicare primary care visits were provided via telehealth in April 2020, compared with less than one percent before the advent of the pandemic.[4] However, the growth was less considerable in rural areas vis-à-vis urban areas.[4] Therefore, although telehealth has been showcased as a primary means for accessing care, and for its ability to address long-standing barriers to accessing care for vulnerable populations, it has also shown to be a vehicle for exposing new barriers.

In January 2017, the AHA released a policy statement that outlined a series of policy recommendations on telehealth and its impact on cardiovascular disease (CVD). It served to inform our efforts in advocating for removing Medicare and Medicaid restrictions on

reimbursement for the use of telehealth technologies in treating CVD patients. These efforts have been supported by a growing body of research that has shown the potential for telehealth to expand access to care.

Impact of Telehealth

Evidence suggests that telehealth can make health care more effective, accessible, and efficient, particularly for those who otherwise lack access to quality healthcare. Telehealth potentially allows quality health care to be delivered to patients in communities where in-person subspecialty services are not available, providing support and training for complex medical conditions to local providers, increasing accessibility for families to specialists, and minimizing time away from work and home. Greater travel distances for services can result in a reduced number of physician visits, increased rates of attrition, and inadequate management of chronic conditions.[5] Telehealth has been shown to be more convenient than traveling to meet a specialist and has resulted in equal or higher patient satisfaction and comparable patient outcomes compared with in-person appointments, making it a viable and beneficial option of care.[6-9]

Impact of Telehealth on Underserved Populations

The COVID-19 pandemic has put a spotlight on health disparities. It is radically exacerbating the deadly consequences of racial and socioeconomic disparities in health care in America, creating a crisis within a crisis. For example, the COVID-19 virus has disproportionately impacted majority racial minority communities and increased closure rates of rural hospitals. These alarming outcomes are in large part the result of longstanding inequities in an array of health determinants, including limited access to health care (especially primary care) and social services and higher rates of chronic disease.

Advances in telehealth technologies have created new opportunities for addressing barriers in accessing quality health care. For example, ownership of cellphones is nearly ubiquitous, regardless of income, education, or race and ethnicity. Further, the majority of low income adults own a smartphone.[10] Such advancements have paved the way for telehealth to increase access to care to underserved populations in both rural and urban areas by broadening specialty care access, reducing travel, decreasing wait time for specialty visits, yielding higher visit rates, reducing missed visits, and improving continuity of care.[11-14]

However, telehealth's potential to expand access to quality care to everyone either during national crises or times of normalcy can be mitigated by factors that can limit their access based on social demographics such as age, race, income, and education level, and contextual factors such as ability to use technology, ability to read and process health information, and level of access to adequate infrastructure and technology. Many of these barriers were well-known prior to the COVID-19, but others have been newly exposed as a result. These barriers are discussed in detail in the next section. Additional barriers are described in Figure 2. Although the AHA and other public health advocates have previously called for telehealth as a potential solution for closing the access gap in underserved areas, its status has been elevated as a result of the COVID-19 pandemic as an essential tool for quality healthcare delivery in populations that have little to no access to healthcare providers or facilities.[12, 13] Prior to the COVID-19 pandemic, underserved populations suffered disproportionately from a lack of access to quality healthcare. They lacked access to primary and specialty care and hospitals were closing at an alarming rate, particularly in rural areas.[15,16, 17] These issues have been exacerbated by the COVID-19 pandemic. And while telehealth has the potential to improve access to care in underserved populations, the benefits of increasing access to it may disproportionally be realized by wealthier communities for several reasons. Some of the major barriers to accessing the benefits of telehealth are listed below.

Barriers to Telehealth Usage

Financial Barriers

Medicare and Medicaid Reimbursement

While some changes were implemented during the COVID-19 pandemic to foster more Medicare and Medicaid reimbursement of telehealth, they were only temporary. Prior to COVID-19, the uncertainty of coverage and reimbursement of telehealth services was a major barrier to its increased use. (cite CHIME survey) Medicare policies were narrowly construed and imposed limitations on where

telehealth services could take place, both geographically and by facility, and what services were covered. Recent temporary changes to Medicare coverage of telehealth (see Table 1 for a summary of Medicare telehealth policy changes) have alleviated some of these limitations for the duration of the pandemic, but some concerns remain. For example, if the temporary changes to Medicare were to expire, telehealth would only be covered in rural areas and would not extend to the patient's home. Additionally, providers in Federally Qualified Health Centers, Critical Access Hospitals, and Rural Health Clinics would not be covered by Medicare for providing telehealth services.

Similarly, Medicaid coverage of telehealth has expanded as states have sought to address barriers to care (see Table 1). Prior to COVID-19, states had significant leeway to determine whether and to what extent patients and providers should be covered for telehealth services. All states and Washington, DC provided some coverage of telehealth in Medicaid, but the definition and scope of coverage varied from state to state.

Commercial Payor Policy

Laws about private insurance coverage and reimbursement of telehealth are also inconsistent from state to state. Prior to COVID-19, 42 states and Washington D.C. had laws that addressed telehealth reimbursement (see definition of payment parity in glossary).[18] However, only 10 of these states required private payers to reimburse telehealth to the same degree as in-person healthcare.[18] This means that in the remaining 32 states, even if telehealth services were reimbursed, they were done so at lower rates than in-person services, thus disincentivizing providers to participate in delivering care via telehealth. As a result of COVID-19, an additional 16 states temporarily required payment parity.[19] This inconsistency of telehealth reimbursement among the states is exacerbated by the fact that only half of them require private insurers to cover telehealth services to the same degree as if the service was delivered in-person (see glossary for definition of "coverage parity").[19]

Technical Barriers

The "Digital Divide"

The term "digital divide" denotes gaps in access to adequate and affordable broadband and technologies such as computers, mobile phones. The elderly and those with low income suffer the most from these gaps.[20-23] Further, the Office of the National Coordinator for Health Information Technology has cited broadband access as a necessary component for telehealth use. Lack of adequate broadband coverage is associated with fewer telehealth visits and hampers the ability of patients to remotely communicate effectively with their provider.[24, 25] Given that the internet has become a fundamental component of so many aspects of daily life, broadband coverage is increasingly recognized as an important social determinant of health as well as a public health issue. According to the Federal Communications Commission, in 2017, 21 million people in the U.S lacked access to broadband.[26] The issue is worse in rural and tribal areas, where nearly 25% and 33% respectively lack such access.[26, 27] Rural areas are more expensive to serve with broadband, due to smaller populations being served over greater distances.

Even in areas where broadband is available, many either do not subscribe or still lack the necessary bandwidth to use telehealth. Video conferencing applications can require connection speeds anywhere between approximately 640 kbps (kilobytes per second) and 2.5 mbps (megabytes per second) with low latency to facilitate a high-quality telehealth encounter. The Office of the National Coordinator for Health Information Technology (ONC) suggests a 10 Mbps connection is suitable for smaller rural health clinics. Such speeds can support video consultations, remote monitoring and image and file downloads (though not in real-time).[28] It also suggests a 25 Mbps connection would be needed for real-time file download and recommends a 100 Mbps connection for larger facilities like hospitals that need more comprehensive telehealth services.[28] To ensure optimal quality, broadband access should be affordable and available in a manner so that the bandwidth necessary for telehealth visits does not surpass monthly limits on data use.

Secondly, while ownership of computers, cellphones, smartphones, and tablets has increased exponentially over the past several decades among most demographics, disparities in usage still exist based on several factors. Households headed by a person 65 or older are disproportionately less likely to have a computer, and over 50% don't own a smartphone.[29] Likewise, low-income vis-à-vis wealthier households and rural vis-à-vis urban populations are disproportionately less likely to own the necessary technology.[30, 31] Further, people coming from low socioeconomic backgrounds often work long and non-traditional hours to have a stable income.[32] Telehealth can

facilitate after-hours availabilities so that it does not compete with income potential.[32, 33] Thus, telehealth services that only require low-cost data plans or audio-only devices may be preferable for low income people.[34]

Lawmakers and regulatory agencies at every level have enacted a variety of initiatives to increase access to broadband. At the federal level, for example, the FCC's Rural Health Care Program and the Department of Agriculture's Distance Learning and Telemedicine Program fund broadband services to expand telehealth availability in rural areas. Current state-level initiatives include public-private partnerships, state-local partnerships, grant programs that specifically target healthcare access via broadband.[35] At the regional level, some communities have embarked on programs that have expanded broadband access to anchor institutions such as civic centers and public schools and libraries.[36] Anchor institutions have been shown to be vital conduits of public services in underserved areas.[36] For example, public libraries in rural areas have higher visitation rates than their urban counterparts despite having fewer operating hours.[37] However, rural libraries often struggle to obtain adequate broadband connectivity due to issues related to cost and infrastructure.[38] These institutions must work with healthcare experts and policy advocates to redesign their space to accommodate high-quality interactions and protect patient privacy.

Lack of Data Privacy and Security

Patients have legitimate concerns regarding the privacy and security of their health data when it comes to using telehealth.[39, 40] The increased reliance on telehealth amid the COVID-19 pandemic amplified these concerns. The Health Insurance Portability and Accountability Act (HIPAA) Security Rule requires that healthcare organizations put in place administrative, physical and technical safeguards to ensure the confidentiality, integrity, and availability of electronic protected health information. However, HIPAA does not have specific requirements related to telehealth. Therefore, a telehealth provider must meet the same requirements of HIPAA as would be needed if the services were delivered in-person. Additionally, states may have their own privacy and security laws with which providers must be familiar.

In telehealth delivery models involving provider-to-provider communication, the entities at both ends are typically required by HIPAA to implement appropriate security safeguards, such as authentication and data encryption measures. However, for healthcare encounters in which the patient is an endpoint, HIPAA does not apply. For example, when a patient communicates with, or sends data to, a provider via his or her smartphone, HIPAA regulations do not apply. Additionally, HIPAA does not apply to healthcare encounters via third-party video-conferencing apps such as Skype or Zoom.

The potential privacy risks posed by provider-to-patient telehealth use include the breach of confidentiality during collection of sensitive data or during transmission to the provider's system, unauthorized third party access to the functionality of supporting devices as well as to data stored on them, and untrusted distribution of software and hardware to the patient.[40] These have the potential to lead to medical identity theft and breaches of sensitive health information.[41]

Social and Cultural Barriers

Lack of Digital Literacy

Merely having access to technology does not mean that a patient will be able to access telehealth. The person must also have sufficient ability or comfort with technology–both software and hardware. Digital literacy (see glossary) impacts access to and benefits from telehealth.[42] In addition, people with disabilities may face additional barriers with telehealth technology. Using telehealth could increase access to care for people with disabilities, but the telehealth technology must be properly matched to the individual's functional or cognitive needs.[43] Additionally, few telehealth technologies explicitly consider digital literacy in their design.[44, 45] Most health systems do not provide training or teaching to populations on how to use these tools, though studies have shown this to be an effective approach for ensuring adoption of telehealth.[46, 47] User familiarity with telehealth technologies and ease of use have been shown to spur their procurement and use.[48-50]

Lack of Digital Health Literacy

Patients with high levels of health literacy (see glossary of terms) have been shown to be more likely to use telehealth.[51] Health literacy interventions that address health disparities have been shown to increase health equity. The processing and use of health information within the context of telehealth has been referred to as digital health literacy (see glossary of terms) and has been shown to be necessary for the adequate use of telehealth.[52] Research has shown that digital health literacy is a central skill set that influences not only how patients seek healthcare, but also the likelihood of engaging in proactive health-related outcomes and experiences.[53, 54]

Research has shown that low income populations have lower levels of digital health literacy.[55] Similarly, research has shown an inverse relationship between age and digital health literacy, with the elderly having lower levels of digital health literacy than younger generations.[56, 57] Therefore, the association of digital health literacy with income and access to technology indicates that telehealth can reinforce existing social chasms when it comes to accessing quality healthcare.[58, 59]

Culture

African American communities have historically been skeptical of U.S. healthcare system, largely due to pervasive example of inhumane treatment and the persistent effects of systemic racism.[33] Immigrant populations may likewise be reluctant to pursue telehealth services due to concerns over confidentiality, privacy, and data security, especially as a result of anti-immigration policies such as increased visibility of U.S. Immigration and Customs Enforcement. [32]

Additionally, language barriers and the availability of interpreter services are significant impediments to telehealth access for non-English speakers in low-income communities. Many telehealth devices and systems are not designed for linguistic adaptability. Adverse health outcomes are more likely if the health information being communicated is not in the patient's native language.[60] According to the Census Bureau, nearly 10% of the U.S. population speaks English "less than well," and many provider systems do not have the capacity to provide language services in the context of healthcare delivery.[61] Finally, the physical absence of the physician serves as a perceived deterrent to telehealth use among many cultures.[32] Telehealth must be designed and implemented with principles of cultural knowledge and competency at heart.

System Barriers

Costs Associated with Provider Procurement, Implementation, and Operation

The costs of procuring telehealth technologies and implementing them within care delivery systems have been shown to be major barriers to realizing their benefits.[62, 63] Steep purchasing and installation costs in particular are cited as barriers to the initial adoption of telehealth.[63] The lack of financial incentives from insurers and government agencies to adopt telehealth systems can exacerbate this barrier.[63-65]

Operating costs have also been cited as potential barriers to telehealth adoption. Specifically, costs associated with data transmission, maintenance, and professional services can be prohibitive, particularly for health systems in underserved communities.[63, 66] Evidence of cost-saving and returns on investment has the potential to facilitate adoption of telehealth by providers. (**cites)**

Lack of Compatibility w/ Clinical Workflow

Evidence has shown that telehealth can't be successfully implemented within provider systems if it is not compatible with the organization's clinical workflow.[62] Providers' perceptions that telehealth impedes workflow, and the delivery of care, are a barrier to both telehealth implementation and use.[63, 67, 68] Telehealth procurement and implementation can be spurred if providers believe it will positively influence clinical workflow.[69] Potential impediments to clinical workflow can be mitigated by telehealth technologies that are designed specifically for care system integration and are user-friendly.[69, 70]

Removing Telehealth Regulations to Address Gaps in Healthcare Access

In early March 2020, the Coronavirus Preparedness and Response Supplemental Appropriations Act was passed. It loosened existing Medicare telehealth restrictions in order to enhance patient access to care services. CMS subsequently expanded the waiver to telehealth reimbursement in certain areas. In late March 2020, the Coronavirus Aid, Relief, and Economic Security Act (CARES) was

passed, which included additional flexibilities for the use of telehealth. The new laws gave the Health & Human Services (HHS) Secretary the authority to waive certain restrictions on telehealth during a declared public health emergency. [1] Also, in March 2020, many states began enacting temporary changes to expand access to telehealth services. For example, though 48 states had already expanded Medicaid to cover telehealth at varying degrees, many further expanded it to cover more telehealth services.[71] Additionally, more states enacted private payer parity and expanded the number of originating and distant sites for telehealth coverage.[71] The temporary changes to Medicare and Medicaid reimbursement are summarized in Table 1.

Many of these of temporary changes have been sought for years and are proving to be vital and have the potential to increase access to quality and affordable care for both the duration of the COVID-19 pandemic and into the future. But barriers remain, and despite an outpouring of support from a number of health care stakeholders, there is still uncertainty as to whether the changes will be made permanent. While access to affordable and adequate care is extremely important during a pandemic, the barriers to care that existed prior to the COVID-19 pandemic remain and new ones have arisen. The actions taken by the Federal and various state governments to expand access to telehealth services have been a step in the right direction, but they have been limited in scope and their impact has been mitigated by disparities in access to adequate broadband and technology. Permanent laws and regulations are needed that establish both public and private reimbursement that is equitable with traditional, in-person care and that does not discriminate based on the patient's or provider's geographical location. Additionally, public health and technological infrastructures must be fully and equitably modernized to ensure that all patients have optimal access to the benefits of telehealth and that all providers have optimal opportunities to procure, implement, and use telehealth to treat patients. As stated above, the AHA believes that telehealth has the potential to expand access to quality care for all. The following guiding principles outline the AHA's position on how policies should be constructed and implemented to ensure barriers to telehealth are addressed and its potential to expand access to quality care to as many people is realized.

Guiding Principles

Guiding Principles for Expanding Access to Care Through Telehealth
#1: Policies should be enacted that ensure everyone, regardless of their geographic location, race and ethnicity, gender, sexual orientation, or socioeconomic status, should have access to telehealth services.
#2: Clinical appropriateness, rather than payment policies, should determine whether telehealth is an acceptable method for healthcare delivery.
#3: Providers, policymakers, and clinical researchers must continue to invest resources to expand the evidence base for telehealth and determine what types of healthcare it can safely and adequately deliver.
#4: For services delivered via telehealth, coverage and payment should be comparable to healthcare delivered in person. For services that can only be delivered via telehealth, policymakers and other key stakeholders must develop fair and reasonable coverage and payment policies.
#5: To avoid fragmentation of care and extract maximum value, telehealth should be incorporated into existing integrated healthcare delivery systems.
#6: Telehealth should be implemented in ways that will strengthen community-based care
#7: Policies should be enacted to ensure that adequate broadband connectivity and telehealth technologies are affordable and widely accessible to everyone.
#8: Telehealth design and implementation should be informed by human-centered design, cultural and linguistic adaptability, accessibility, and usability principles in order to ensure that all levels of technological acuity can benefit from it.

[1] CCHP table of Medicare changes

#9: Whenever applicable, policies should be enacted that ensure all telehealth encounters adhere to the same principles that apply to in-person encounters with respect to data accuracy, patient safety, civil liberties, and privacy.

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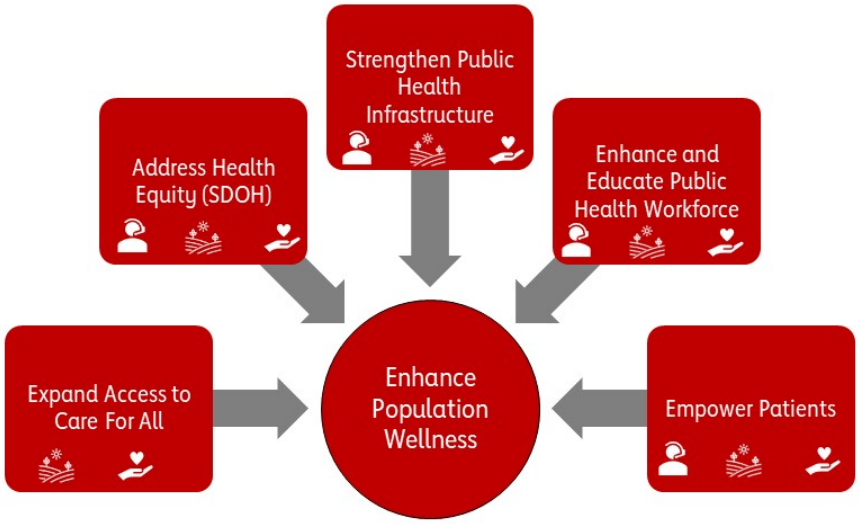
APPENDIX A: Glossary Of Terms

Glossary of Terms	
Telehealth	The use of medical information exchanged from one site to another via electronic communications to improve patients' health status.
Originating Site	Location of the patient at the time the service being furnished via a telecommunications system occurs.
Distant Site	Site at which the physician or other licensed practitioner delivering the service is located at the time the service is provided via telecommunications system.
HIPAA	Acronym for Health Information Portability and Accountability Act. The HIPAA Privacy Rule protects the privacy of individually identifiable health information, the HIPAA Security Rule sets national standards for the security of electronic protected health information, and the confidentiality provisions of the Patient Safety Rule protect identifiable information being used to analyze patient safety events and improve patient safety.
Payment Parity	The requirement that private payers in a state have to reimburse for telehealth services at the same rate they do for in-person care.
Coverage Parity	The requirement that private payers in a state have to cover telehealth services to the same degree they do for in-person care.
Digital Literacy	The ability to use information and communication technologies to find, evaluate, create, and communicate information, requiring both cognitive and technical skills
Health Literacy	The ability to gain access to, understand and apply health information to positively influence their own health and the health of those in their social environments.
Digital Health Literacy	The ability of people to use emerging information and communications technologies to improve or enable health and health care.

Figure 1: Crosswalk of Previous Relevant AHA Policy Statements



Recommendations for the Implementation of Telehealth in Cardiovascular and Stroke Care

Call to Action: Rural Health

Advancing Healthcare Reform: The American Heart Association's 2020 Statement for Principles for Adequate, Accessible and Affordable Health Care

Figure 2: Additional Barriers to Telehealth Usage

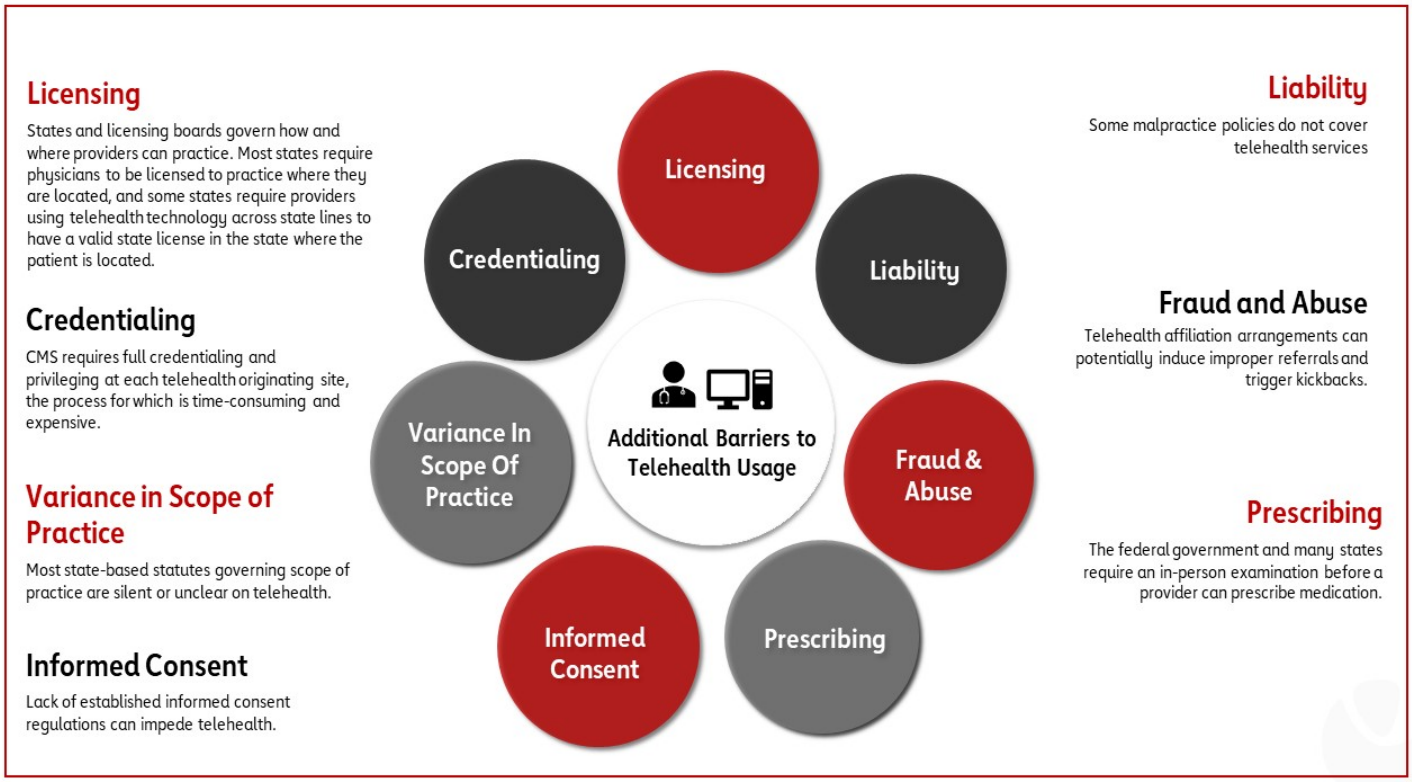


Table 1: Summary of Temporary Medicare and Medicaid Changes to Telehealth Reimbursement

Relevant Changes to Medicare and Medicaid Telehealth Coverage: COVID-19				
Medicare				
Subject Area	**Policy Pre-COVID-19**	**COVID-19 changes**	**Barriers that remain unaddressed**	**Expiration date**
Geographic Location	Patient must be located in a non-Metropolitan Statistical Area (MSA) or a rural Health Professional Shortage Area (HSPA).	No geographic restrictions.	• Change is only temporary. • State laws governing the practice of medicine are still in place.	End of the Public Health Emergency (currently 10/22/2020).
Originating Sites	Originating sites eligible for telehealth reimbursement included: • Provider offices • Hospitals • Rural Health Clinics • Critical Access Hospitals • Federally Qualified Health Centers • Skilled Nursing Facilities • Community Mental Health Centers • Hospital-based or critical access hospital-based renal dialysis centers • Mobile Stroke Units (for acute stroke only)	List of eligible originating sites now includes the patient's home.	• The patient's home is not an originating site on a permanent basis (the proposed 2021 Physician Fee Schedule only made it permanent for substance abuse treatment).	End of the Public Health Emergency (currently 10/22/2020).
Distant Sites	Federally Qualified Health Centers and Rural Health Clinics are not authorized to serve as distant sites for telehealth consultations in Medicare	List of eligible distant sites now includes: • Provider's home • Rural Health Clinics • Federally Qualified Health Centers	• Changes are only temporary.	End of the Public Health Emergency (currently 10/22/2020).
Eligible Providers	The following types of providers were eligible	CMS' proposed 2021 Physician Fee		The proposed Physician Fee Schedule is

	for telehealth reimbursement: • Physicians • Nurse practitioners • Physician assistants • Nurse midwives • Clinical nurse specialists • Clinical Psychologists • Clinical Social Workers • Registered dietitians or nutrition professionals	Schedule clarified that the following providers can provide brief assessments and check-ins via telehealth and remote evaluation on a permanent basis: • Clinical social workers, • Clinical psychologists • Physical Therapists • Occupational therapists • Speech language pathologists can provide brief assessments and check-ins via telehealth and remote evaluation		currently open for public comment. The final schedule will take effect on 01/01/2020.
Medicare Advantage	Medicare Advantage plans had the flexibility to have more expansive telehealth policies related to types of services covered, where those services can take place (no geographic or site limitations), modality used.	Medicare Advantage Organizations may waive or reduce cost sharing for telehealth services, as long as plans do this uniformly for all similarly situated enrollees.	Waivers or reductions in cost sharing for telehealth services are only voluntary. Plans may vary in their likelihood of implementing cost sharing.	
Modality	Providers could only be reimbursed for using technology that had audio and video components.	Providers may be reimbursed for audio-only telehealth visits on a temporary basis. The proposed 2021 Physician Fee Schedule is seeking	Change is only temporary	End of the Public Health Emergency (currently 10/22/2020). The proposed Physician Fee Schedule is currently open for public comment. The final

		comment on whether this change should be made permanent.		schedule will take effect on 01/01/2020.
Healthcare Delivery	CMS required that supervising physicians be on site in order to fulfill its "direct supervision" requirement of outpatient-based services.	During the public health emergency, CMS allowed direct supervision to be provided via telehealth. The proposed 2021 Physician Fee Schedule, allow physicians to fulfill direct supervision requirements while remote, provided the physician is immediately available to engage via audio-video technology if needed.	• Change is only temporary.	End of the Public Health Emergency (currently 10/22/2020). The 2021 Physician Fee Schedule will take effect on 01/01/2021.

Medicaid		
Policy Pre-COVID-19	**Temporary COVID-19 Changes**	
• Most states and Washington D.C. provided some coverage but the definition and scope of coverage varied from state to state. • The most commonly covered modality of telehealth was live video. Few states permitted "audio-only" telephone care to qualify as a telehealth service. • 19 state FFS Medicaid programs allowed patient's to access telemedicine from their homes.	• CMS gave states broad authority to expand telehealth within their Medicaid programs. • As a result, most states allowed both FFS and managed care Medicaid beneficiaries to access services from their home, and most are directing Medicaid plans to allow for reimbursement for some telephone evaluations. • Many states allowed FQHCs and RHCs to serve as distant site providers. • Many states expanded which professions qualify as eligible to provide telehealth services through Medicaid.	• Medicaid coverage for telehealth is not uniform across the states. • States differ on what originating and distant sites can be covered by Medicaid. • States differ on what providers are eligible to bill Medicaid for telehealth services

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