Telehealth Equity

Office of Legislative Oversight Memorandum Report 2020-11

December 8, 2020

By Kristen Latham, Senior Legislative Analyst

Telehealth is the "*use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.*" Due to the COVID-19 pandemic and resulting stay-at-home orders, the use of telehealth across the country has significantly increased.

However, the increase in virtual care creates new barriers to equitable access to care. Telehealth reform efforts should be coupled with significant and targeted investment to bridge the digital divide and to remove barriers for underserved and vulnerable populations. This OLO memorandum report responds to the Council's interest in learning about telehealth and the inequities that may result from increased use. Specifically, the report:

- Section I summarizes the definition of telehealth and recent changes in telehealth-related legislation as a result of the pandemic;
- Section II provides information on telehealth legislation and policies in Maryland and Montgomery County;
- Section III summarizes the disparities among telehealth use and best practices to ensure equity; and
- Section IV includes options for next steps.

I. Background on Telehealth

Information and communication technologies (ICTs), such as computers, the Internet, and cell phones have changed the way individuals communicate, seek and exchange information, and provide/receive services. One field that can greatly benefit from these advancements in technology is healthcare - telehealth/telemedicine has the potential to make healthcare more accessible, efficient, and better coordinated.

Prior to the COVID-19 pandemic, the use of telemedicine in the United States was minimal. However, the pandemic has led to the rapid expansion of telehealth as policymakers, insurers, and health systems have looked for ways to deliver care to patients in their homes in order to limit transmission of the novel coronavirus, reduce staff exposure to ill persons, preserve personal protective equipment (PPE), and minimize the impact of patient surges on facilities. In the post-pandemic era, telehealth could provide greater access and convenience for some patients.

This section summarizes (A) the definition of telehealth and the benefits/concerns about telehealth, followed by (B) a review of the recent changes in telehealth policy as a result of the pandemic.

A. Definition of Telehealth

Telehealth (sometimes referred to as telemonitoring) is the use of digital information and communication technologies, to access health care services remotely and manage health care. Telehealth refers to a broader scope of remote healthcare services compared with telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services, such as provider training, meetings, and continuing medical education, in addition to clinical services. The diagram below summarizes the differences between the two.
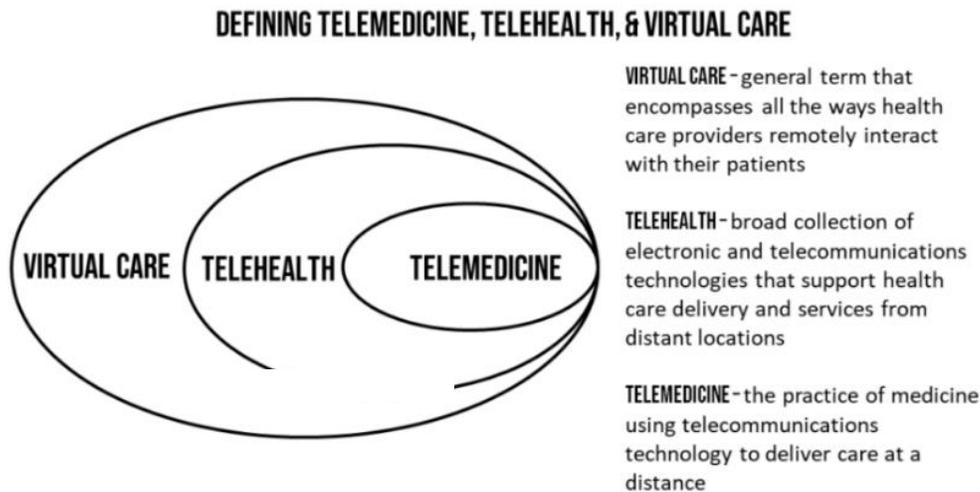
Source: "Telehealth and Telemedicine," American Academy of Family Physicians

There is no one definitive definition of telehealth – each entity has their own definition, although most are similar. The Health Resources Services Administration (of the Federal Department of the Health and Human Services) defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration." Telehealth utilizes technology to provide health care and other health-related services between patients and providers, as well as communication between providers.

There are four primary methods of telehealth, according to the timing of the information transmitted and the interaction between the individuals involved.[1]

- **Asynchronous or store-and-forward** telemedicine involves the exchange of pre-recorded data between two or more individuals at different times. Messages, images, or data are collected at one point in time and interpreted and/or responded to later. Often, patient portals facilitate this type of communication between provider and patient through secure messaging.
- **Synchronous or real-time** telemedicine requires the involved individuals to be simultaneously present for immediate exchange of information, including real-time telephone or live audio-video interaction.
- **Remote patient monitoring** allows direct transmission of a patient's clinical measurements from a distance (may or may not be in real time) to their healthcare provider, such as collecting a patient's vital signs or other health data while the patient is at home, and transferring the data to a remote provider for monitoring and response as needed.
- **Mobile health (mhealth)** is an emerging field that includes patient engagement, patient education, and public health programs offered via mobile communication devices. Specifics may include targeted text messages that promote healthy behavior, wide-scale alerts about disease outbreaks, or apps to help patients self-diagnose illnesses.

Some specific examples of telehealth include: [2]

- Electronic personal health record system (PHR) is a collection of information about health that is controlled by the patient.
- Applications on a phone that can record vital signs, calculate and track caloric intake, schedule reminders for taking medicine, and record physical activity.
- Online patient portals provide a more secure online tool to communicate with your doctor, request prescription refills, review test results and summaries of previous visits, schedule appointments or request appointment reminders, and provide a single point of communication for any specialists.
- Virtual appointments via online videoconferencing.
- Virtual consultations from doctor to doctor.
- Education and training for health clinic personnel that are not locally available, particularly in rural areas.

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[1] Source: Health Resources and Services Administration, NCSL, 2015
[2] https://telehealth.hhs.gov/

Telemedicine Can Facilitate a Broad Range of Interactions Using Different Devices and Modalities

Interactions	Devices	Modalities	Patient Location
• Patient to provider • Provider to provider	• Smartphone • Computer/tablet • Monitoring device	• Videoconference • Remote patient monitoring • Phone* • Secure messaging*	• Home (or location of choice) • Clinic/Office • Hospital

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Note: *Not considered telemedicine by many definitions and therefore not covered by most insurers

Use of Telehealth. The Department of Health and Human Services estimates that more than 60% of all health care institutions and 40-50% of all hospitals currently use some form of telehealth.[3] Prior to the COVID-19 pandemic, the use of telehealth was increasing but overall, was still minimal. FAIR Health provides a summary of the use of telehealth in recent years (prior to the pandemic)[4]:

- From 2014 to 2018, use of non-hospital-based provider-to-patient telehealth grew 1,393%, from 0.007% to 0.104% of all medical claim lines.
- In 2018, non-hospital-based provider-to-patient telehealth accounted for 84% of all telehealth claim lines, compared with 52% in 2014.
- From 2014 to 2018, usage of non-hospital-based provider-to-patient telehealth grew more rapidly in urban than rural areas. In urban areas, claim lines for this type of telehealth increased 1,227% from 0.01% to 0.13% of all urban medical claim lines. In rural areas, the increase was 897% from 0.01% to 0.05% of all rural medical claim lines.
- In the period 2014-2018, the age group most associated with telehealth overall was that of individuals age 31-40, who accounted for 21% of the distribution of all telehealth claim lines.
- Acute upper respiratory infections were the number one reason individuals sought treatment from a provider for non-hospital-based telehealth in 2018 (16%).

However, FAIR data analysis of their Monthly Telehealth Regional Tracker shows a significant increase in use of telehealth during the pandemic - telehealth claim lines increased 8,336% nationally, from 0.15%

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[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5389433/
[4] FAIR Health analyzed recent data in a repository of over 29 billion private healthcare claim records. It excludes Medicaid and Medicare. https://www.fairhealth.org/press-release/telehealth-claim-lines-increase-8-336-percent-nationally-from-april-2019-to-april 2020?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosfutureofwork&stream=future

of medical claim lines in April 2019 to 13% percent in April 2020. In addition, at the 2020 American Telemedicine Association conference, telehealth company Amwell stated that about 20% of office visits have transitioned to telehealth, with a potential increase of 25–30% visits after the pandemic ends.[5]

Benefits of Telehealth.[6] There are many potential benefits of telehealth for both medical practitioners and patients:

- *Accessibility.* Increases accessibility of healthcare for people who live in rural, isolated, or underserved communities and make healthcare more readily available or convenient for people with limited mobility, time or transportation options.

- *Specialist Access.* Provides access to medical specialists from different geographic locations to be seen by patients.

- *Health Care Team Coordination.* Improves coordination among members of a health care team and patient by allowing primary care physicians and specialists to share information and communicate with each other and the patient.

- *Infection Control.* Assists with infection control - fewer patients and staff present in waiting rooms and clinic buildings unnecessarily can allow space in clinics for those patients who really need to be seen in-person.

- *Quality.* Provides a quality of healthcare services as good as those given in traditional in-person consultations, depending on the specialties.

- *Quicker Access.* Enables patients to get certain types of care when they need it instead of having to travel to a facility or waiting to get an appointment. Telehealth can provide immediate assistance until the patient can get to a facility, if needed.

- *Cost Reduction.* Reduces the cost and increased efficiency for medical systems and patients through the reduction of overhead costs; decrease in higher cost services (urgent care and ER visits) due to improved access; reduction emergency department visits and the time patients spend in hospitals, and decreased travel expenses.

Concerns About Telehealth.[7] While telehealth can have numerous benefits, there are significant concerns about its use, specifically how it may exacerbate already existing health disparities. Some specific concerns include:

- *Access to Technology***.** The most significant barrier to telehealth is access to technology, often due to low socioeconomic status and the limitation of infrastructure. Stable internet connection and technological devices are essential and not available to everyone. Some specific impacts include: (1) digital literacy and acceptance of technology amongst older adults, black and brown patients, and non-English speaking patients; (2) individuals with disabilities may have issues with telehealth; and (3) individuals in rural areas in which access to broadband internet is limited.

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[5] https://www.nejm.org/doi/full/10.1056/NEJMsr1503323
[6] https://www.mayoclinic.org/healthy-lifestyle/consumer-health/in-depth/telehealth/art-20044878
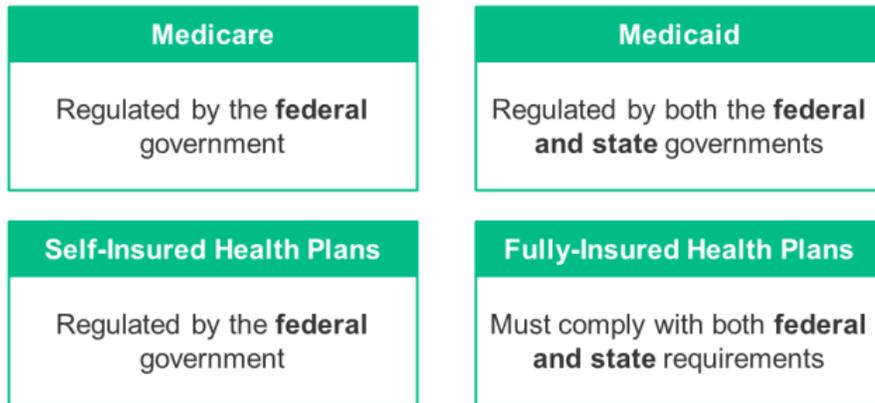[7] https://www.ncbi.nlm.nih.gov/books/NBK207146/

- *Technical Difficulties*. Even if a patient has reliable access to technology, technical difficulties can impact patient-physician communication. There may be an burdensome sign-on process, an awkward user interface that makes it difficult to find what they are looking for, or a requirement to download multiple new apps.

- *Acceptance of Virtual Visits.* There may be issues with the cultural acceptance of conducting virtual visits in lieu of in-person visits. Further, the lack of accessible translation services creates additional barriers for non-English speaking patients.

- *Licensure.* States have varying licensing regulations, which can be a challenge for telehealth providers. While virtually all physicians must be licensed in the state in which they physically practice, a number of states require that physicians must also have a valid license in the state where the patient is located.

- *Insurance/Reimbursement.* While many of these concerns have been temporarily addressed during the COVID-19 pandemic, many insurance companies may not cover telehealth services, or do not provide reimbursement at the same rate as in person services. Opponents of telehealth argue that telehealth services are not equivalent to in-person services and therefore should not receive parity to in-person services in reimbursements.

- *Privacy Concerns.* While telehealth complies with HIPAA laws, which aim to prevent private or secure medical documents, there is no guarantee that routine data transmissions from an app or medical device would not be shared with third-party advertisers or others.

- *Coordination of Treatment.* While telehealth has potential for better coordinated care, it also has a risk of fragmenting health care which can lead to gaps in care, overuse of medical care, inappropriate use of medications, or unnecessary or overlapping care.

- *Medical Errors and Patient Safety.* Without the ability to physically be in a room with a patient, a doctor is limited in the care they can provide – it can hinder the exchange of information and the taking of vital signs.   For some diagnoses, the absence of the traditional face-to-face encounter may increase the risk of medical errors, which causes concerns for practitioners about medical malpractice cases.

B. Changes in Telehealth Policy as Result of COVID

There is no uniform legal approach to telehealth in the United States – it is primarily dictated by laws and regulations at the federal and state levels. Overall, states have significant control over telehealth policy and reimbursement schemes for telehealth services, both within their state Medicaid programs as well as through laws governing private insurers. The Kaiser Family Foundation created the graphic below to summarize how telehealth is regulated.

Figure 3

Who Regulates Telemedicine in Health Plans?

Medicare	Medicaid
Regulated by the **federal** government	Regulated by both the **federal and state** governments

Self-Insured Health Plans	Fully-Insured Health Plans
Regulated by the **federal** government	Must comply with both **federal and state** requirements

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Because of the COVID-19 pandemic, many federal and state laws have undergone policy changes to reduce barriers to telehealth access and have promote the use of telehealth as a way to deliver acute, chronic, primary and specialty care. The following summarizes significant changes in telehealth policy.

Medicare and Medicaid Changes. The Centers for Medicare & Medicaid Services (CMS) have issued multiple waivers providing flexibility during the COVID-19 Public Health Emergency. This includes granting payment parity between telehealth and in-person clinical care for Medicare. Medicaid is administered at the state level and states can choose whether or not to cover telehealth services (many have). All of these expanded telehealth services are not limited to COVID-19 related services, rather they are available to patients regardless of diagnosis and can be used for regular office visits, mental health counseling, and preventive health screenings.

CMS has issued temporary measures to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the COVID-19 Public Health Emergency. Some of these changes include:

- Medicare will pay physicians for telehealth services at the same rate as in-person visits;
- Medicare and many state Medicaid programs have allowed for audio-only, or telephonic, care;
- Physicians can utilize telehealth for both new and established patients;
- Patients can receive telehealth services in all areas of the country and in all settings (not just rural settings), including at their home;
- Patients can receive treatment from an out-of-state provider who is not licensed in their state;
- CMS will not enforce a requirement that patients have an established relationship with the physician providing telehealth;
- Consent for telehealth services may be obtained by staff or the practitioner at any time, required only once on an annual basis; and
- Medicare will make payment for telehealth services furnished to beneficiaries in any healthcare facility and in their home.

CMS also significantly expanded the list of types of clinicians and covered telehealth services that can be provided by Medicare through telehealth to include:

- Emergency department visits;
- Initial nursing facility and discharge visits;
- Home visits;
- Therapy services, including physical and occupational therapists and speech language pathologists; and
- Cost-sharing for patients in federal health care programs.

Payment Parity Among Private Insurers.   As stated earlier, Medicare and Medicaid have addressed payment parity between telehealth and in clinic care, requiring equal reimbursement. However, private insurers are free to decide which telehealth services their plans will cover if there is no state mandate. Payment also remains a problem at state boundaries, because in many cases, billing is not approved across states.

In response to the COVID-19 pandemic, many states are mandating fully-insured private plans to cover and reimburse for telemedicine services equally to how they would for in-person care (service parity and payment parity). Further, many major health insurance companies have voluntarily expanded telehealth coverage for fully-insured members in their response to COVID-19, focusing on reducing or eliminating cost sharing, broadening coverage of telemedicine and expanding in-network telemedicine providers.

New Department of Health and Human Services Telehealth Website.[8] The Federal Department of Health and Human Services (DHHS) has created a website to help physicians and patients get started with telehealth services. This website provides resources and best practices for accessing care virtually, with many resources coming from the American Medical Association (including their Telehealth Implementation Guidebook). Other specific resources provided include information on:

- CARES Act Provider Relief Fund
- Operation Warp Speed
- Testing
- Community-Based Testing Sites
- Testing Plans

- Grant Opportunities and Guidance
- COVID-19 News
- Telehealth
- Mental Health and Coping
- Optimizing Ventilators

HIPAA flexibility during COVID-19. Typically, the Health Insurance Portability and Accountability Act (HIPAA) requires health organizations and providers to protect patient privacy and health information. HIPAA is designed to reduce healthcare fraud and abuse by setting industry-wide standards for health care information and requires the protection and secure handling of specific patient health information. Many people mistakenly believe that communicating electronic personal health information (ePHI) at distance is acceptable when the communication is directly between physician and patient, but it can be a violation of HIPAA.

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[8] https://www.hhs.gov/coronavirus/telehealth/index.html

However, due to the pandemic, the HHS Office for Civil Rights has issued guidance that enables health care providers to expand the use of telehealth – even if they may not fully comply with the requirements of HIPPA.[9] The directive allows HIPAA-covered health care providers to provide telehealth services to patients using remote communication technologies, such as commonly used apps such as FaceTime, Zoom, or Skype, even if the application does not fully comply with HIPAA rules. HHS will not impose penalties for HIPAA violations that occur during the good faith provision of telehealth during the COVID-19 pandemic.

Changes in Licensing. Health practitioners must be licensed to practice in states where they offer telemedicine services and states regulate which health professionals are credentialed to practice in their state. Some states participate in "compacts" that allow providers in participating states an expedited process to practice in other compact states. This can be problematic for practitioners that need to cross state lines to help alleviate healthcare burdens, such as the pandemic. In response to COVID-19, almost all states are moving to temporarily waive out of state licensing requirements, so that providers with equivalent licenses in other states can practice via telehealth. The Federation of State Medical Boards is tracking these updates and finds that currently 49 states have issued waivers regarding licensure requirements during the COVID-19 pandemic.

CARES Act Provider Relief Fund. The Coronavirus Aid, Relief, and Economic Security (CARES) Act Provider Relief Fund was established by Congress to provide financial relief (grants) to physicians, hospitals, and other providers during the COVID-19 pandemic. The CARES Act includes additional funding to the Telehealth Network Grant Program (TNGP), which includes $29 million over five years for telehealth technologies used in rural areas and medically underserved areas. The bill also ends funding for the Telehealth Resource Center (TRC) Grant Program, which is currently funding TRCs at roughly $4.6 million-a-year for four years.

Controlled Substances. Under the Controlled Substances Act, the Drug Enforcement Agency (DEA) requires an in-person evaluation before a provider can prescribe a controlled substance, limiting telemedicine's use for e-prescribing of controlled substances without a prior in-person patient-provider relationship. The DEA has made two changes related to prescribing controlled substances during the COVID-19 pandemic:

- A practitioner can prescribe a controlled substance to a patient using telemedicine, even if the patient is not at a hospital or clinic registered with the DEA; and
- Qualifying practitioners can prescribe buprenorphine to new and existing patients with opioid use disorder based on a telephone evaluation.

Providers must still comply with state laws; however, many states have issued emergency orders to remove in-person requirements before engaging in telehealth, including Maryland.

Consent Laws. Many states require providers to obtain and document informed consent from patients before engaging in a telehealth visit. In most states, verbal consent is allowed, but in a minority of states, consent must be obtained in writing. For Medicaid patients, some states that required written consent have now allowed verbal consent.

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[9] https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Federal Bills Proposed Regarding Telehealth

There are numerous proposed pieces of legislation in Congress currently that aim to improve access and efficacy of telehealth presently and after the end of the pandemic.

- **Telehealth Modernization Act** would make several telehealth proposals permanent, including: removing geographic and originating site restrictions from Medicare coverage of telehealth services; ensuring that telehealth services at federally qualified health centers (FQHCs) and rural health clinics (RHCs) are covered by Medicare; expanding the types of telehealth services covered by Medicare and the types of care providers who are able to deliver those services; and enabling Medicare to cover more telehealth services used for hospice and home dialysis care.

- **COVID-19 Telehealth Program Extension Act** would provide the now-shuttered COVID-19 Telehealth Program $200 million to allow the Federal Communications Commission to fund more telehealth programs.

- **COVID-19 Emergency Telehealth Impact Reporting Act**, the **KEEP Telehealth Options Act** and the **Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act**, require HHS to collect data on telehealth use during the pandemic for an in-depth study on its effectiveness.

- **Telehealth Expansion Act**, the **Advancing Telehealth Beyond COVID-19 Act**, and the **Protecting Access to Post-COVID-19 Telehealth Act**, would make certain telehealth freedoms enacted during the pandemic permanent.

- **Equal Access to Care Act**, would allow care providers to use telehealth in any state to treat patients in any location for up to 180 days after the end of the COVID-19 emergency.

- **Helping to Ensure Access to Local telehealth (HEALTH) Act** extends telehealth coverage to FQHCs and RHCs.

- **Telehealth Response for E-prescribing Addiction Therapy Services (TREATS) Act** expands telehealth coverage for substance abuse treatment.

In addition, the American Telemedicine Association, Alliance for Connected Care, and the National Committee for Quality Assurance (NCQA) have organized a new task force aimed at lobbying Congress to continue to increase telehealth access and coverage beyond COVID-19. It has a goal of developing "consensus recommendations for policymakers on how to maximize the benefits of telehealth services while maintaining high standards for patient safety and program integrity."

II.   Telehealth in Maryland and Montgomery County

As stated in the last section, the regulation of telehealth is dictated primarily at the federal and state levels but varies greatly by state, including Maryland. This section summarizes (A) the rules and regulation of telehealth in Maryland and (B) the implementation of telehealth in Montgomery County.

A. Telehealth Law in Maryland

The State of Maryland defines telehealth as:

> *Telemedicine means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology: (1.) By a health care provider to deliver a health care service that is within the scope of practice of the health care provider at a site other than the site at which the patient is located; and (2.) That enables the patient to see and interact with the health care provider at the time the health care service is provided to the patient. Telemedicine does not include an audio-only conversation between a health care provider and a patient; an electronic mail message between a health care provider and a patient; or a facsimile transmission between a healthcare provider and a patient.*

The Center for Connected Health Policy summarized the laws and regulations of telehealth laws in each state in the Spring of 2020.[10] The following tables summarize Maryland's laws and policies.

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[10] https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report

Maryland Telehealth Law: Medicaid and Medicare

Medicaid
Live Video
Maryland Medicaid covers live video telehealth conducted by specific providers and in specific originating sites. Eligible services include diagnostic interview, individual therapy, family therapy, group therapy, outpatient evaluation and management, outpatient office consultation, emergency department services. Eligible originating sites include: college or university student health or counseling office; community-based substance use disorder provider; deaf or hard of hearing participant's home or any other secure location approved by the participant and provider; elementary, middle, high or technical school with a supported nursing, counseling or medical office; local health department; FQHC; hospital, including emergency department; nursing facility; private office of a physician, physician assistant, psychiatric nurse practitioner, nurse practitioner, or nurse midwife; opioid treatment program; outpatient mental health center; renal dialysis center; or residential crisis services site.
Store and Forward
Medicaid program does not reimburse for store-and-forward[11] - dermatology, ophthalmology and radiology are excluded from the definition of store-and-forward.
Remote Patient Monitoring
Does reimburse for remote patient monitoring for patients with certain chronic conditions and exhibiting certain risk factors, including chronic obstructive pulmonary disease, congestive heart failure, and diabetes.
Consent
An individual must voluntarily consent to telehealth services, which must be documented in the individual's medical record. If the participant is unable to provide consent, the medical record must contain in writing an explanation as to why the participant was unable to consent to services rendered via telehealth.
Reimbursement Restrictions
Only providers who are HIPAA compliant and meet Technical Requirements may bill for services rendered via telehealth. Reimbursement is not allowed for email, telephone or FAX.
Technology Requirements
Providers must have minimum technology available, including a camera that has the ability to provide multiple views of a patient and capability to alter resolution and focus; bandwidth speed and image resolution sufficient to provide quality video, and audio equipment that ensures clear communication and includes echo cancellation. Also, all tech staff must be trained in telehealth technology use and HIPAA compliance.
Medicare
Before the 1135 Waiver in March 2020 (*see page 8*), the person receiving the service must be in a designated rural area. Under the waiver, Medicare can pay for office, hospital, and other visits furnished via telehealth across the country and including in patient's places of residence. There are three main types of virtual services physicians and other professionals can provide to Medicare patients: telehealth visits, virtual check-ins, and e-visits.

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[11] Store-and-forward technologies allow for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through secure email communication.

Maryland Telehealth Law: Private Payer Laws

Requirements
Insurers must provide coverage under a health insurance policy for health care services appropriately delivered through telehealth and may not exclude coverage solely because it is provided through telehealth and not in-person. A health insurance policy or contract may not distinguish between patients in rural or urban locations in providing coverage under the policy or contract for health care services delivered through telehealth.
Payment Parity
There are no explicit payment parity laws.
Reimbursement
Insurers must reimburse a health care provider for the diagnosis, consultation and treatment of an insured patient that can be appropriately provided through telehealth.

Maryland Telehealth Law: Other Regulations

Prescribing
A telehealth practitioner (1) may not prescribe opioids for the treatment of pain through telehealth except if the patient is in a health care facility as defined in the Annotated Code of Maryland; (2) may not treat a patient or prescribe medication based solely on an online questionnaire; (3) may perform a synchronous, audio-visual patient evaluation adequate to establish diagnoses and identify underlying conditions to recommended treatment options before providing treatment or prescribing medication; and (4) may use surrogate examiner or a patient evaluation performed by another licensed health care practitioner.
Interstate Licensing
Maryland is a member of the Interstate Medical Licensure Compact, which includes 29 states and the District of Columbia. The Compact provides an expedited path to a separate license in each participating state. Maryland also has exceptions to its MD-only licensed physicians for physicians practicing in the adjoining states of Delaware, Virginia, West Virginia, and Pennsylvania if the physician does not have an office or other regularly appointed place in the State to meet patients and the same privileges are extended to licensed physicians in Maryland by the adjoining state.

Recent Maryland State Bills Regarding Telehealth. Prior to the COVID-19 pandemic, Maryland enacted laws to expand and improve the access to and coverage for telehealth services in the state, summarized below. Both of these measures were passed into law and will not end when the pandemic ends, unlike many COVID-19 emergency related legislation.

House Bill 448 and Companion Senate Bill 402
- Adds asynchronous telemedicine to the state's telehealth guidelines   - Allows providers to use telehealth to establish the doctor-patient relationship   - Requires the provider to adhere to the same standards as for in-person care   - Establishes guidelines for prescription of controlled substances   - Allows for referral of a patient to in-person services or another type of telehealth service
House Bill 1208 and Companion Senate Bill 502
- Requires the state's Medicaid program (Maryland Medical Assistance Program) to provide telemental health services to patients in their homes   - Amends the state's telehealth definition to include telemental health in the list of services covered by certain insurers, non-profit health service plans, and health maintenance organizations   - Requires the Maryland Department of Health to apply to the Centers for Medicare & Medicaid Services by Dec. 1, 2020 for a waiver to launch a pilot program to deliver chronic care management services via telehealth to Medicaid recipients regardless of where that member is located, thus allowing for home-based virtual care   - Requires Department of Health to report back to the Legislature by December 1 and provide updates on the program every six months   - Requires State to study whether substance use disorder services can be provided via telehealth to Medicaid recipients.

The Governor also signed numerous executive orders expanding the use of telehealth during the emergency, signing those bills into law as emergency act so they took effect immediately. The Maryland General Assembly also passed House Bill 1663 (Companion Bill Senate 1080), State of Emergency and Catastrophic Health Emergency, which allows the Governor to establish or waive telehealth protocols, including authorizing health care professionals licensed out-of-state to provide telehealth to patients in the state.

Maryland Health Care Commission and Telehealth. The Maryland Health Commission (MHCC) is working with various stakeholders to provide information on telehealth. The MHCC has provided a Telehealth Virtual Resource Center to provide resources on telehealth topics, webinars, and a Telehealth Policy Workgroup, composed to review telehealth policies temporarily implemented in response to the COVID-19 public health emergency that ought to continue after the PHE ends.

The MHCC has also won a series of grants beginning in late 2014 and running through to 2019 to support the adoption of telehealth services. Their work includes the cultivation of on-demand webinars, tools, guides, designating a point person for telehealth adoption, and more. Some of MCMS's most often referred to MHCC telehealth materials include the following:

- Telehealth Adoption – Office-Based Physicians
- Telehealth Professional Liability Insurance Flyer
- Telehealth Readiness Assessment (TRA) Tool
- Telehealth Reimbursement Flyer

The Maryland Health Care Commission (MHCC) has awarded 17 telehealth grants to qualified organizations to implement innovative telehealth projects in Maryland across various care settings. Grantees report on telehealth outcomes against measures that align with project goals. Lessons learned from these projects inform better practices and industry implementation efforts, create policy development to advance use of telehealth, and advance planning and design of larger telehealth projects across the State. One example of a grant was "Expanding Telehealth Adoption in Ambulatory Practices" - $500,000 was awarded in May 2020 to three State-Designated Management Service Organizations to provide technical guidance to ambulatory practices in the State in order to support adoption of telehealth during the COVID-19 public health emergency and after.

A. Montgomery County Telehealth

The Montgomery County Department of Health and Human Services (DHHS) is responsible for public health and human services that protect the community's health, protect the health and safety of at-risk children and vulnerable adults, and address basic human needs including food, shelter and clothing. Public Health Services within DHHS is leading the County's COVID-19 response, including the Public Health Command Center, testing centers, and vaccination distribution (when that occurs).

Prior to the COVID-19 pandemic the Department was not providing any services through the use of telehealth. However, when the pandemic began, many programs in DHHS started to implement telehealth services. Most DHHS staff are currently working remotely.

For now, each service area (and program within those service areas) have determined what programs and services it can provide through telehealth, and which requires in-person services. Some services, such as child and adult welfare checks, the Crisis Center, and home care for those with disabilities, cannot be completely virtually. Therefore, each program determines which services must remain in person and which can be done through telehealth (and which telehealth platform). The table below outlines some examples of how DHHS is using telehealth. Overall, OLO found that when the program or service is capable of being done remotely, the Department will provide the service through telehealth.

Department of Health and Human Services Telehealth Examples

Service Area	Telehealth Status
Children, Youth and Family Services	*Combination of telehealth and in-person services.* Child Welfare Services uses a combination of telehealth and in-person. Positive Youth Development uses telehealth through partners. Linkages to Learning and School & Community-Based Youth Services are using telehealth through partners. The Infants and Toddlers Program is entirely using telehealth. The Program (with MCPS) is providing Chromebooks and Hot Spots for residents for clients identified by case workers.
Aging and Disabilities Services	*Combination of telehealth and in-person services.* Services that can be provided over telehealth are being provided through telehealth. Working with OATS (Older Adults Technology Services) to have young people train seniors or people with disabilities to use technology.
Behavioral Health and Crisis Services	*Combination of telehealth and in-person services.* Crisis Center is still open. DHHS has created technology hubs across the County for users to access telehealth.
Public Health Services	*Most services still in person.* Care for Kids and Montgomery Cares provide telehealth services, at the discretion of the individual providers. DHHS is developing a telehealth policy for Montgomery Cares.

As stated above, each program uses a telehealth platform that meets its individual needs. However, the Department is currently seeking a contract with Zoom Health (see discussion below) to consolidate all of DHHS telehealth into a single platform. All DHHS staff reported that the ultimate goal for DHHS after the pandemic is to continue to provide the option of telehealth for users in the long-term.

County Telehealth Funding – COVID-19. The Council has recently passed numerous bills as part of the Coronavirus Relief Fund providing various supports during the COVID-19 pandemic, including for health services, economic recovery, and housing support. Resolution Number 19-535 is the only legislation that OLO identified that directly provided funding for telehealth. The resolution stated that the County "must use $500,000 of this special appropriation for a grant program to help Montgomery County-based independent medical and dental practices expand telehealth and implement other innovations to increase and enhance patient access to healthcare, with a focus on reducing disproportionate health outcomes." This does not mean that County departments did not use any other Relief Fund funding for telehealth.

Telehealth Workgroup. Once the COVID-19 pandemic began, DHHS formed a workgroup to address the implementation and use of telehealth within the department, both for staff and users. Representatives from each Service Area were included in the workgroup, which was charged with the following:

- Identifying a HIPAA compliant telehealth platform for use across DHHS and guidance on how to operationalize it;
- Developing a draft policy for the appropriate use of telehealth technology; and
- Developing telehealth informed consent practices to be used across DHHS.

Further, the work group discussed and addressed language interpretation service needs and the integration of telehealth technology and EMR (electronic medical records).

The work group recommended Zoom Health as the telehealth platform the County should use; this recommendation was approved by the Director and the Department is currently pursuing a contract for the services. As part of this process, each service area identified how many licenses it would need and created a "life of the case" model, or workflow map. The workgroup finalized other recommendations regarding the implementation of telehealth policies and submitted the report to the DHHS Director, where it is currently awaiting review and approval.

Challenges of Telehealth. OLO spoke with DHHS staff, who identified the following challenges the Department has faced since the implementation of telehealth across the Department:

- Access to adequate broadband and technological devices;
- Not enough technology hubs across the County to meet the needs of those who do not have access to resources;
- Language barriers pose a significant problem;
- Virtual visits do not allow for proper demonstration of some services/devices that users need;
- Virtual visits are difficult for some users when sensitive information needs to be shared; and
- Some telehealth platforms are not user friendly.

Health Equity and Telehealth. DHHS' Office of Community Affairs is responsible for "promoting health equity, improving quality of services, and increasing individual and family self-sufficiency, especially among racial and ethnic minorities and low-income communities." In 2009, DHHS formed an Equity Workgroup that aimed to engage staff at all levels in providing equitable health services to all users. In 2013, the Department started equity training and staff estimate that currently about 50% of DHHS have received this training.

The Office of Community Affairs, in conjunction with the Workgroup, has created Equity Standards that guide the Department's actions to "improve quality, expand access and eliminate inequities." When implementing these standards, DHHS is meant to keep the following communities in mind: Blacks, Asians, and Latinos; low-income residents; LGBTQIA+; people with physical or mental disabilities; immigration status; and Limited English Proficiency.

DHHS Health Equity Standards

1. An integrated service delivery system equitably supported by technology, which enables staff to share information and work collaboratively for improved client outcomes.
2. Recruit, develop and maintain a workforce that is engaged, accountable, responsible, respected, recognized and prepared for changing roles within the Department and representative of the community we serve.
3. Working in partnership with the community, focus on the promotion of community health and well-being and the prevention of adverse outcomes.
4. Services to customers are delivered in a respectful manner and in the context of the customer's culture, language, values, and beliefs.
5. Print and multimedia communication materials and forms are developed in easy to understand language, taking into consideration literacy level, cultural and linguistic appropriateness and people with other forms of communication needs.
6. Program hours are accessible to customers, wait time for walk in services will be reasonable, appointments will be kept on time.
7. Locations for direct services have adequate parking and are accessible by public transportation with the physical layout of the exterior and interior adopting a universal design approach to accommodate people of diverse ability.
8. Each employee understands disparities, inequities, the social determinants of health and wellbeing and is knowledgeable about community issues, needs and resources.
9. Data standards are in place to accurately describe, measure, and evaluate disparities and inequities in ways that are compliant with federal and other funding requirements.
10. Decision tools supported by quantitative and qualitative data are applied to assist in determining policies and equitable distribution of resources.
11. Clear strategies for community engagement that focus on capacity building, creation of public policy, data collection and data sharing that supports health and equity across communities.

When the COVID-19 pandemic began, DHHS immediately started recovery planning to ensure that services were still being provided. As part of the recovery plan, the Service Access Equity Workgroup was created, which, along with the Office of Community Affairs, provides guidance to service areas to ensure equity in the development of new service delivery methods due to COVID-19. While the service areas figure out the best way to implement telehealth and other services, the Office of Community Affairs supports them in equity efforts.

As part of the recovery effort, DHHS developed a set of six questions and guidance for the DHHS Recovery Planning Process. These questions were provided to all service areas when developing plans and policies for the use of telehealth:

1. Who is and who is not at the table making the decision? How can this body be more inclusive?
2. Who will benefit from the decision?
3. Who will be burdened by the decision? Explain Why? How will the burden be mitigated?
4. What current community profile, data and on the ground information are you using to shape your decision? What information is missing?

5. How will this decision create/enhance access, based on the needs and circumstances of the communities (e.g. literacy level, language, transportation, mobility, access to internet, location of services, etc.)?
6. How Is the decision aligned with the HHS Equity principles?

Telehealth in Local Jurisdictions

OLO reviewed other local jurisdictions' websites to determine what telehealth options were available for residents in those jurisdictions. OLO was able to find very limited information on the availability of telehealth through local health departments. This does not mean that local departments are not providing telehealth services, just that OLO was not able to find information online.

One jurisdiction that does have limited information on telehealth is the Fairfax County Health Department and Community Services Board (which provides services for people of all ages who have mental illness, substance use disorders and/or developmental disabilities). Fairfax County is providing essential services at clinic locations but is also offering telehealth services such as therapy, counseling, case management and prescribing, via Zoom for Healthcare and by phone or video.

III.   Disparity of Access to Telehealth and Best Practices to Ensure Equity

Health equity is the absence of disparities or avoidable differences among socioeconomic and demographic groups or geographical areas in health status and health outcomes such as disease, disability, or mortality.[12] With its potential to overcome workforce and access barriers, telehealth can reduce health disparities for aging and underserved populations (low-income and/or rural), as well as reduce patients' costs and burdens associated with lost work time, transportation and child care.

However, the use of telehealth could have negative implications for marginalized groups that already face discrimination within health care settings, influencing their willingness to trust providers and seek medical attention. Disparities in digital access and literacy can further exacerbate this marginalization particularly among rural populations, older adults, racial/ethnic minority populations, and those with low socioeconomic status, limited health literacy, and limited English proficiency.

This section provides an (A) overview of the available statistics on inequity in telehealth and (B) best practices to help ensure equity in the use and quality of telehealth.

A. Statistics on Telehealth Inequity

Prior to the COVID-19 pandemic, the use of telehealth was uncommon. Although 76% of hospitals in the United States had partial-to-full implementation of telehealth in 2017, the actual use of telehealth remained low. One study examining a large commercially insured population found that in 2017, there were 6.57 telehealth visits per 1,000 members. [13] The following summarizes the limited data available on telehealth use prior to and during the COVID-19 pandemic.

Use of Telehealth. OLO identified three studies that look at inequity in telehealth use, summarized below.

US National Health and Wellness Survey Study.[14] This study reviewed the National Health and Wellness Survey data and Komodo Health's "payer-complete" claims data from March 2019 and March 2020. Overall, the study found that telehealth claims increased 845.0% from 0.2% in March 2019 to 1.9% in March 2020, representing an absolute increase of 1.7%. Respondents who had a telehealth encounter compared with an in-person encounter tended to be younger, female, Hispanic, married or living with a partner, and employed. More specifically:

- Patients aged 18–44 years were more likely to have a telehealth encounter than an in-person visit compared with older age groups.
- Patients living in the Northeast, Midwest, or West regions of the US were more likely to have had a telehealth encounter than those living in the South.
- Patients with anxiety or depression were more likely to have a telehealth encounter than an in-person encounter.
- Married respondents were less likely to have had a telehealth encounter compared with those who were single, divorced, or widowed.

This study found that race overall is not a significant predictor of telehealth use. However, respondents identifying as Asian-only compared with White-only were less likely to have a telehealth encounter. The study

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[12] https://www.hrsa.gov/about/organization/bureaus/ohe/index.html

[13] https://www.liebertpub.com/doi/10.1089/POP.2020.0186

[14] https://www.liebertpub.com/doi/10.1089/POP.2020.0186

further found that overall, other patient characteristics, such as sex, ethnicity, and employment status were not statistically significant predictors of telehealth use.

UCSF General Internal Medicine Practice Study.[15] This study looked at patients at the University of California San Francisco Department of Medicine and the Richard Fine People's Clinic at Zuckerberg San Francisco General Hospital during the beginning of the COVID-19 pandemic. The study compared the two-week period before telemedicine implementation (February 17–28) to a two-week period after implementation (March 23 – April 3).

Overall, researchers found that video visits increased from 3% of weekly visits to 80% of weekly visits. Telephone visits also increased from 0% to 16%.   The study found that there are significant disparities in the use of telehealth, shown in the chart below:

- Visits of adults 65 years and older decreased from 41% to 35%;
- Visits of non-English language preference adults decreased from 14% to 7%; and
- Visits of those insured by Medicare (from 43% to 22%) and Medicaid (17% to 10%) both decreased.

Patient Visits by Age, Language, and Insurance Before and After Telemedicine Scale-Up

This chart shows the proportion of patient visits seen by age, language preference, and insurance type prior to (2/17–2/28/2020) and after (3/23–4/3/2020) scaled-up telemedicine implementation to address the Covid-19 pandemic at the UCSF General Internal Medicine Primary Care Practice (P=0.002 for age ≥65 and P<0.001 for other comparisons). A significantly smaller proportion of visits after scaled-up telemedicine implementation were with vulnerable patients.
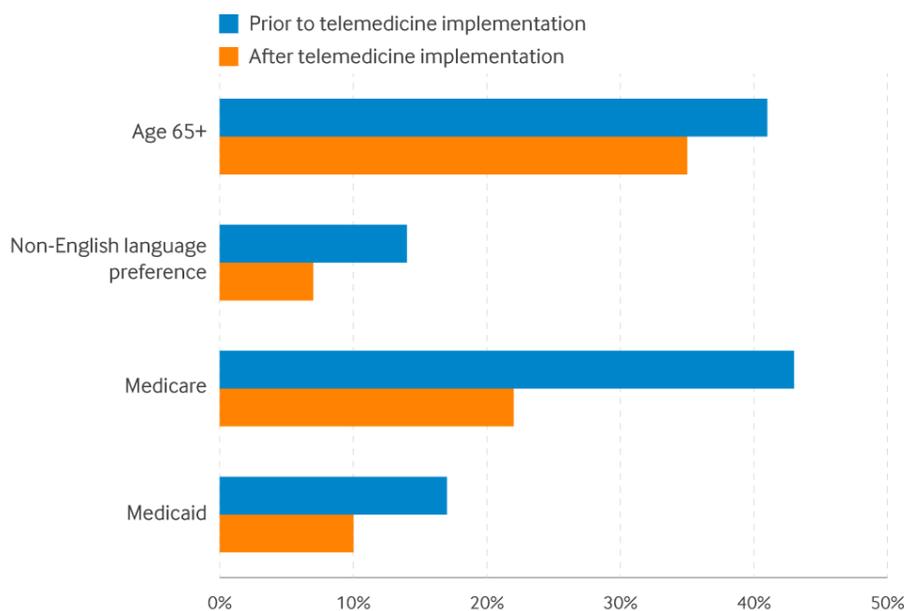
Source: The authors
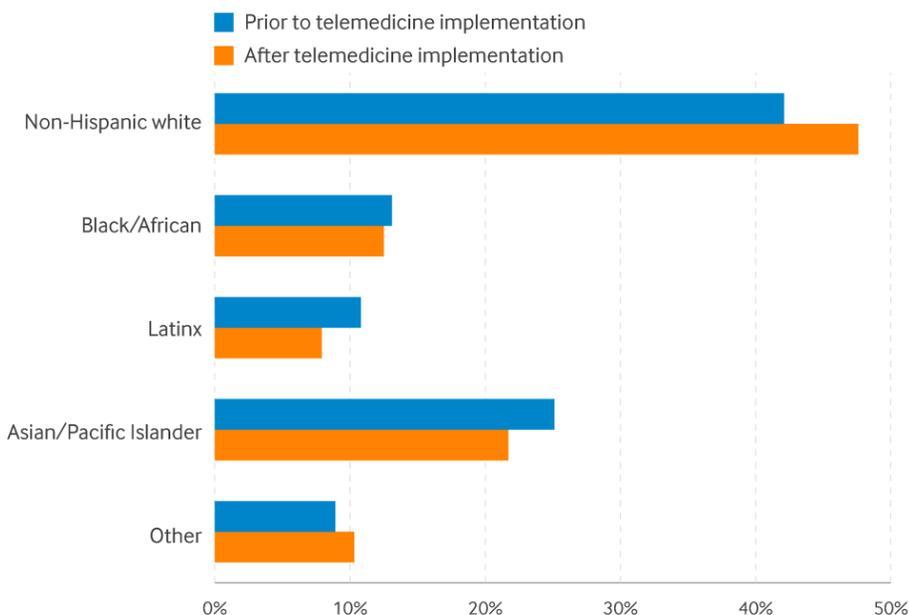NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Source: https://www.nejm.org/doi/full/10.1056/NEJMsr1503323

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[15] https://catalyst.nejm.org/doi/full/10.1056/cat.20.0123

The study also looked at telehealth visits related to race/ethnicity. Shown by the chart below, researchers found that patients identifying as Non-Hispanic White, and Other represented a higher proportion of visits while all other groups (Black/African-American, Latinx, and Asian/Pacific Islander) were a smaller proportion of visits.

Patient Visits by Race/Ethnicity Before and After Telemedicine Scale-Up

This chart shows the proportion of patient visits seen by patient race/ethnicity prior to (2/17–2/28/2020) and after (3/23–4/3/2020) scaled-up telemedicine implementation to address the Covid-19 pandemic at the UCSF General Internal Medicine Primary Care Practice (P=0.006 using chi-squared test). A smaller proportion of visits with vulnerable populations occurred after implementation.

Source: The authors
NEJM Catalyst (catalyst.nejm.org) © Massachusetts Medical Society

Source: https://www.nejm.org/doi/full/10.1056/NEJMsr1503323

Black Book and Sage Growth Partners. In a Black Book and Sage Growth Partners survey of 591 U.S. healthcare consumers[16], researchers found that the majority of respondents (78%) who have used telehealth were satisfied with their experience. However, there were disparities in use:

- The majority of consumers age 55 to 64 (81%) and age 65+ (84%) who have access to telehealth have not had a virtual or telemedicine visit; and
- Only 36% of people making less than $25,000 say they have access to telehealth; more than half (55%) of people making $50,000 to $100,000, 70% of those earning $100,000 to $200,000, and 70% of those with an income of more than $200,000 have access.

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[16] https://www.healthcareitnews.com/news/telehealth-use-rises-new-trends-highlight-demographic-divides

COVID-19 Related Use of Telehealth. A study[17] was conducted that reviewed the characteristics of patients who sought care or testing voluntarily for COVID-19 through (1) telehealth; (2) ER encounters; and (3) office visits/in clinic care. The data was from Mount Sinai, a New York City hospital in the epicenter of the COVID-19 during the initial outbreak. Overall, researchers looked at just under 40,000 patient encounters between March 20 and May 18 and found there were key health disparities in telehealth use and access during the initial stages of the pandemic - older adults and Black and Hispanic patients were less likely to utilize the technology than their White and Asian peers.

- Overall, 38.3% of all first encounters were via the emergency department, 38.5% are via telehealth, and 23.2% occur at an outpatient office.
- White (47% of visits), Asian (40% of visits), and those in the "other/unknown" category (44% of visits) were more likely to use telehealth than their Black and Hispanic peers.
- Black (60% of visits) and Hispanic (48% of visits) patients were more likely to access the emergency department.
- Forty-one percent of patients ages 18 to 29 used telehealth; 47% of those ages 30 to 49 used telehealth; and 24% of adults over age 65 used telehealth.
- Only about a quarter of Spanish-speaking patients chose telehealth over the emergency department.

Researchers made note that there may be other factors that lead to these results:

- Black and Hispanic patients were more likely to contract the virus and become sicker with it, which may make them more likely to visit the emergency department first.
- Patients without a source of usual care (e.g., a primary or specialty care physician) would be more likely to go to the emergency department, and less likely to seek telehealth treatment through previously established care relationships.

Further, researchers stated "We include race as a predictor in our model because documenting racial/ethnic differences for public awareness is a necessary first step in reducing disparities, however we view race as a social construct. The formal and informal policies and interactions rooted in inequality, discrimination, oppression and exclusion, which underlie this construct and engender factors we hypothesize are contributing to our results, should also be addressed in future research."

Access to Technology. Because access to technological resources and adequate broadband access is essential for the use of telehealth, OLO also looked the statistics on this access from numerous studies and found:

- 97% of Americans in urban areas have access to high-speed fixed service and only 65% and 60% have access in rural areas and tribal lands, respectively.[18]
- Only 55%–60% of adults 65 years and older own a smartphone or have home broadband access; from within that group, 73% use the Internet, 60% can send an email, fill out a form, and find a website.[19]
- Low-income individuals have lower rates of smartphone ownership (71%), home broadband access (59%), Internet use (82%), and basic digital literacy (53%). [20]

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[17] https://academic.oup.com/jamia/advance-article/doi/10.1093/jamia/ocaa216/5899728
[18] https://www.liebertpub.com/doi/10.1089/POP.2020.0186
[19] https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123
[20] https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123

In a study completed by Medicare,[21] researchers found that 41.4% of Medicare beneficiaries lacked access to a desktop or laptop computer with a high-speed internet connection at home, and 40.9% lacked a smartphone with a wireless data plan. Twenty six percent of people had access to neither. Further, access varied by demographic and socioeconomic groups:

- 50.1% of beneficiaries with income of 100% below the federal poverty level lacked digital access compared with 11.5% of those with income 400% or more above the federal poverty level.
- The proportion of Medicare beneficiaries with digital access was lower among those who were 85 or older, were widowed, had a high school education or less, were Black or Hispanic, received Medicaid, or had a disability.

B. Best Practices to Address Telehealth Inequity

In the long term, telehealth can increase access to all patients but only if the right investments are made to ensure equity to vulnerable populations with limited digital literacy or access, such as rural residents, racial/ethnic minorities, older adults, and those with low income, limited health literacy, or limited English proficiency. The expansion of current national and state level support for telehealth services with a focus on vulnerable populations is an important step to improving telehealth access.

In an article for the NEJM Catalyst Innovations in Care Delivery Journal,[22] researchers summarized what health systems can do to ensure equitable access to telehealth, shown by the chart below.

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[21] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2768771
[22] https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123

Recommendations with Key Actions for Clinicians and Health Systems to Consider in Order to Ensure Equitable Access to Telemedicine

Goal	Key Actions

Identify potential disparities in access	Explore potential improvements in access to care (e.g., number of visits) for patient subgroups with known limited digital literacy and access
	  - Older adults
	  - Low socioeconomic status
	  - Limited health literacy
	  - Limited English proficiency
	  - Racial/ethnic minorities
	Continue monitoring data to evaluate impact of any interventions

Mitigate digital literacy and resource barriers	Develop education and training to teach patients the digital skills to conduct video visits Inform patients about newly free or reduced-cost broadband Internet in their area
Remove health system–created barriers	Offer video visits to every patient Ensure adequate language interpreter access Screen for patients at high risk of not being able to engage in video visits (no device, Internet/data, privacy) Consider offering telephone visits if unable to mitigate barriers to video visits Increase system leadership awareness of barriers to telemedicine
Advocate changes to support sustained and equitable access	Permanent expansion of low-cost or free broadband Funding for telemedicine expansion in less resourced health centers Pay parity for telephone and video visits by all payers

Source: https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123

The remainder of this section details how local jurisdictions can use these recommended actions as a basis for helping to ensure that there is equitable access among private health systems, but also in providing health services through the government.

Proactively Explore Potential Disparities in Telemedicine Access. The ability to accurately track telehealth trends (COVID-related or not) by race, ethnicity, sex, age, socioeconomic status, disability status, and location is vital to providing equitable public health interventions. Data should also be collected on technology access, literacy, and privacy of healthcare providers and patients. This data on telehealth access/use is critical to address disproportionate effects and to ensure that resources are equitably distributed.

Data should be reliably and consistently reported and available to health care systems, state and local health departments, government agencies, and the public, which can be used to coordinate and direct resources to those who have the highest need. Without accurate data representatives of all providers and patients, governments and health systems cannot appropriately evaluate the unique challenges facing different communities.

Develop Solutions to Mitigate Barriers to Digital Literacy and the Resources Needed for Engagement. Adequate broadband access is critical to the use of telehealth. Many populations reside in locations or are individually subjected to the challenges of not having broadband access due to the cost or availability. As a result, it is important for governments at all levels to promote universal access to high-speed broadband, including expanded infrastructure or discounted mobile or broadband service. One approach for expanding broadband has been creating technology "hubs" in which healthcare providers, schools, and libraries are aligned into a telehealth-care hub so that patients can access technology not available in their homes.

One key aspect of ensuring digital literacy is that providers and patients must have proper hardware and software, and if needed, technical assistance, to support telehealth implementation in underserved regions. To address disparities in ownership of digital devices, local governments could provide/loan/discount laptops and smartphones or supply internet hotspots and phone-charging stations for these communities to enable telehealth access.

Moreover, many low-income patients lack digital literacy. Virtual telehealth platforms should design applications with interfaces that are intuitive and easy to navigate. Patients who are not familiar with telehealth systems should have access to training and support guides. Providers and governments should be especially aware of the digital divide among individuals with disabilities and older adults.

Remove Health System Barriers to Accessing Telehealth. There are treatment barriers created by health systems that may be exacerbated by the use of telehealth. Governments at all levels and health systems should work to establish policies or laws that ensure that these barriers do not preclude a patient from using telehealth.

- *Privacy.* Privacy and data security are of high priority in securing sensitive, personal health data and allowing patients to feel comfortable enough to use the platform. Policies must be put in place that ensure support for existing HIPAA regulations that prioritize patient privacy. This is particularly important for vulnerable communities who may already be distrustful of the healthcare system.

- *Cultural Distrust.* There is significant evidence of healthcare inequities that disproportionately affect many communities of color, including higher rates of chronic diseases, lower access to health care, lack of paid sick leave, lack of or inadequate health insurance, and income disparities, all of which can impact

a patient's ability or desire to access telehealth services. Recognizing and acknowledging this history of discrimination and exploitation of communities of color and the distrust of the medical system that results from it is critical to move forward on efforts to build trust and improve outcomes.

It is imperative for providers working with minority and immigrant communities to ensure confidentiality and instill trust in order to fully assess a patient's concerns and issues. This is especially true of mixed documentation communities, in which it is common for these families to be guarded about household size, living accommodations or working arrangements due to fear of being found out and reported to immigration authorities. In addition, most federal relief efforts and public healthcare insurance coverage programs restrict access to undocumented or recent immigrants. These exclusions severely impact their ability to seek needed or urgent testing, treatment and care due to concerns about financial and legal repercussions.

- *Language Barriers.* Similar to many other government services, a common barrier to providing quality health services information is that there may not be providers or information available in a patient's spoken language. If adequate translation services are not available within the telehealth platform, a patient may choose to not use telehealth or receive health services at all.

Advocate for Policies and Infrastructure that Facilitate Equitable Telehealth Access. Governments at all levels have made changes to law in order to support the increased use of telehealth during the COVID-19 pandemic, including relaxing telehealth written consent, licensing, and online prescribing laws and expanding coverage. These policies are aimed at increasing access to telehealth and lessening disparities in its use. Legislators, healthcare providers, and telehealth supporters should advocate to for continuing these changes past the pandemic, when they are set to expire:

Written Consent. Healthcare providers must obtain and document the patient's informed consent for the telehealth services, including explaining of the risks and benefits of receiving telehealth services, along with any information reasonably necessary to obtain effective consent. Many states have loosened the requirements of written consent to include either verbal or electronic consent.

Licensing. Under normal circumstances, most healthcare providers must be licensed in any state where they see patients, virtually or in person. In response to the pandemic, many states have temporarily waived in-state licensing requirements for healthcare professionals who hold a valid out-of-state medical license or granted temporary emergency licenses to providers to operate across state lines.

Prescribing. The Federal Government issued a rule that practitioners may issue prescriptions for controlled substances to patients for whom they have not conducted an in-person medical evaluation, given certain criteria are met. Many states have also permitted some form of online prescribing or loosening prescribing requirements during the COVID-19 emergency. This has allowed the prescribing of necessary controlled substances through telehealth, reducing inequities in patients who were not able to (or did not want to) enter a facility to see a provider.

Reimbursement/Parity. Coverage and reimbursement of telehealth is still far from uniform between payors and most changes to telehealth policy are temporary. State governments have legislated numerous changes to telehealth policy to increase use and decrease disparity. Some of those include:

- Ensuring service parity and payment parity for telehealth care;

- Expanding covered services for patients (including all health services, including mental and behavioral health, as well as physical, occupational and speech therapy) and incentivizing clinicians to provide this model of care;
- Removing onerous restrictions on the types of services covered via telehealth, audio/video requirements, and geographic and originating sites of telehealth;
- Ensuring patients can access telehealth services from their homes;
- Allowing use of audio-only phone for telemedicine visits; and
- Investing in telecommunications infrastructure for those who do not have or cannot afford access.

IV.   Next Steps

As a result of the COVID-19 pandemic, the Federal Government, many state governments and commercial insurers are expanding coverage of telehealth and relaxing existing regulations, including expanding coverage, relaxing requirements regarding consent, licensing, prescribing, and providing technological infrastructure support. While these measures have been taken to broaden telehealth access during this pandemic, there continue to be gaps in coverage and access to telehealth. There are inequities among access to telehealth resources based on race, socioeconomic status, and language (among other things). Healthcare systems also do not know the long-term impacts of COVID-19 or the future status of the Affordable Care Act and how this will impact telehealth. As telehealth programs continue to adapt and evolve, there must be a focus on achieving and maintaining health equity.

DHHS has already implemented telehealth across all service areas where it can. The Department also created a Telehealth Workgroup that submitted recommendations, which the Director is currently reviewing. The Council can discuss with Department of Health and Human Services staff and other stakeholders the possible next steps to improve the current use of telehealth in the department and the plan to continue its use past the pandemic. *The County Executive will provide comments on this report for any later worksesssions.*

1.   Advocate that Telehealth Laws Enacted During Pandemic Remain Past Legislation End Date

Most telehealth policies and regulations occur at the federal and state levels. Many of the changes that the federal and state governments have enacted regarding telehealth policy are directly related to the COVID-19 pandemic and therefore temporary. These policies are aimed at increasing access to telehealth while striving to ensure equity. If Montgomery County would like to invest in telehealth over the longer term, more permanent measures may need to be enacted.

While there are concerns around a greater implementation of telehealth (such as privacy or limited access), it must be determined by policymakers, payors, and providers to determine if the changes made to telehealth policy in light of COVID-19 outweigh these potential concerns. If the Council believes the changes should remain permanently, OLO recommends that the Council advocate for changes at the state and federal policy levels to make telehealth more accessible and equitable while ensuring quality care. Some of these policies (which have been enacted on a temporary basis) include:

- Expansion of low-cost or free broadband Internet access;
- Ensuring service parity and payment parity for telehealth care as compared to in-person care;
- Easement of regulations on licensing and geographic areas where telehealth can be utilized;
- Expansion of covered services for patients;
- Ensuring patients can access telehealth services from home (as "originating site"); and
- Allowing use of audio-only phone for telehealth visits.

2.   Provide Technology Resources and Support for County Providers/Staff and Patients, Including Language Interpretation Services

Disparities in access to technology, especially adequate broadband access, can further exacerbate disparities in other social determinants of health. The use of telehealth services must have a focus on vulnerable populations.

The County's Department of Health and Human Services has adapted to delivering services that can be delivered through telehealth. Each Service Area has implemented specific telehealth technology to meet its need; the

Department as a whole is in the process of implementing the department-wide platform of Zoom Health. One critical need that numerous DHHS staff identified was improved language interpretation services through the current technology.

While the Department has implemented telehealth across all service areas, there can still be improvement. The Council can discuss with DHHS staff where there are continued technology needs, among staff and users. The Council could discuss the funding of equipment and infrastructure (including Zoom Health licenses) to meet the needs of staff and users who do not have access to adequate technology and help decrease inequities The Council could further discuss partnering with or supporting community organizations working on these efforts for increased digital access and literacy or expanding capacity for government, nonprofit, and community-based organizations to do this work. Increasing partnerships with various stakeholders to provide access and technology to users for telehealth services, and assuring data privacy and integrity, will be crucial for ensuring that telehealth is sustainable and equitable going forward.

The mission of the Montgomery County (MD) Office of Legislative Oversight is to provide accurate information, analysis, and independent findings and recommendations that help the Montgomery County Council fulfill its legislative function.

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