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Telehealth Transformation in COVID-19

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I INTRODUCTION

Telehealth surged to the forefront of health care delivery during the COVID-19 pandemic. Though it has existed for years, telehealth has long faced legal, regulatory, and economic barriers to widespread adoption in the United States. The COVID-19 pandemic forced the health care system to rapidly adapt to overcome significant challenges, including those relating to reimbursement rules, regulation of online prescribing, privacy laws, and licensing requirements.

The policy changes implemented during the pandemic allowed for the adoption of telehealth at lightning speed and are in many ways unlikely to be rolled back even after the pandemic concludes. Yet while this natural experiment with telehealth demonstrated its overall effectiveness and received high patient satisfaction, concerns remain regarding telehealth's appropriateness in some health care contexts, its cost-effectiveness, its potential for exacerbating existing health disparities, and its risks of fraud and abuse. Further, many of the policy changes implemented during the pandemic were temporary; failure to make changes permanent will limit telehealth's future success.

This chapter engages with the transformation of telehealth use and regulation during the COVID-19 pandemic. After examining the historical and current barriers to telehealth adoption, we detail the explosive growth of telehealth during the pandemic, as well as the challenges that remain for the field's future success.

II BACKGROUND

Telehealth, sometimes referred to as telemedicine, is the provision of medical, public health, and health education services remotely – when a patient and provider are in different locations – using technology. Telehealth may involve real-time communications with a provider using audio-video or audio-only devices, the transmission of health information manually or through a medical device, or data tracking using a mobile health application.

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Telehealth has existed in some form for more than seventy years and has grown significantly in recent decades. Radiological images were first sent by telephone in 1948, from West Chester, Pennsylvania to Philadelphia. In 1959, the Nebraska Psychiatry Institute began providing psychiatric consultations by videoconference. The National Aeronautics and Space Administration started telehealth projects in the 1970s, providing telehealth to rural patients in at least six states. Many large telehealth companies formed in the 2000s, providing services to patients directly or through partnerships with insurers or health systems.

Despite its long history and growth before the COVID-19 pandemic, telehealth's role in the US health care system was limited. Telehealth use was increasing by 30–50 percent per year prior to the pandemic, but adoption rates were still very low.[1] Only 0.25 percent of Medicare beneficiaries had used a telehealth service in 2016, and only 840,000 Medicare fee-for-service telehealth visits occurred in 2019.[2] For large employer plans, only 0.8 percent of beneficiaries in 2016 and 2.4 percent of beneficiaries in 2018 had used a telehealth service.[3] In February 2020, fewer than six services per 1,000 Medicaid and Children's Health Insurance Program beneficiaries were delivered via telehealth.[4]

Many factors contributed to telehealth's limited success. First, limited telehealth coverage and reimbursement by payers, or even a complete lack thereof, as well as lower rates of reimbursement as compared to in-person visits, deterred patient and provider adoption. Second, licensing laws have traditionally been barriers to telehealth adoption, as most states and Medicare require providers be licensed in the state where the patient is located. Third, state laws and federal health regulations restricting the creation of a doctor–patient relationship via telehealth, often requiring an initial in-person encounter, have prevented or discouraged telehealth adoption. Fourth, telehealth prescribing of certain medications was restricted by federal laws and regulations prohibiting prescribing without an in-person evaluation or requiring in-person dispensing. Last, health privacy laws have limited the

[1] Ateev Mehrotra et al., Telemedicine: What Should the Post-Pandemic Regulatory and Payment Landscape Look Like?, The Commonwealth Fund (Aug. 5, 2020), www.commonwealthfund.org/publications/issue-briefs/2020/aug/telemedicine-post-pandemic-regulation.

[2] Information on Medicare Telehealth, Ctrs. for Medicare & Medicaid Servs. (Nov. 15, 2018), www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf; Lok Wong Samson et al., Medicare Beneficiaries' Use of Telehealth in 2020: Trends by Beneficiary Characteristics and Location 1 (Assistant Sec'y for Plan. & Evaluation, US Dep't of Health & Human Servs. Dec. 2021), https://aspe.hhs.gov/sites/default/files/documents/a1d5d810fe3433e18b192be42dbf2351/medicare-telehealth-report.pdf.

[3] Matthew Rae et al., Coverage and Utilization of Telemedicine Services by Enrollees in Large Employer Plans, Peterson-KFF Health System Tracker (Mar. 3, 2020), www.healthsystemtracker.org/brief/coverage-and-utilization-of-telemedicine-services-by-enrollees-in-large-employer-plans/.

[4] Rose C. Chu et al., State Medicaid Telehealth Policies Before and During the COVID-19 Public Health Emergency 1 (Assistant Sec'y for Plan. & Evaluation, US Dep't of Health & Human Servs. July 2021), https://aspe.hhs.gov/sites/default/files/2021-07/medicaid-telehealth-brief.pdf.

technologies that can be used for telehealth, prohibiting the most commonly used and easily accessible platforms, such as Zoom or FaceTime.

III CHANGES TO TELEHEALTH REGULATION IN COVID-19

The COVID-19 pandemic demanded rapid changes virtually overnight. Medical providers suspended non-essential in-person appointments and procedures to curb the spread of the virus and to reduce the burden on a medical system under unprecedented pressure. Both government and health care stakeholders across the country implemented new laws and policies to resolve many barriers to the use of telehealth.

A *Coverage Parity*

Government and private payers moved quickly to increase telehealth coverage and reimbursement. Historically, Medicare covered telehealth only if the patient was in a rural area, and even then required patients to go to an "originating site" to receive the care (typically a provider's office).[5] In March 2020, the Department of Health and Human Services (HHS) used its authority under Section 1135 of the Social Security Act to issue a waiver lifting this restriction by permitting non-rural patients to receive telehealth services and the patient's home to be an "originating site" of care.[6] Medicare also had previously required telehealth be delivered in real time using both audio and video technologies. While this requirement largely remained, the Centers for Medicare and Medicaid Services (CMS) issued a rule allowing reimbursement for behavioral health and patient education services provided via telehealth when patients only have audio-only phones.[7] CMS also added 144 additional telehealth services to its covered services list.[8] Many of these services were temporarily covered through the duration of the public health emergency. CMS extended permanent coverage to many behavioral telehealth services, including audio-only telehealth services, and temporary coverage to several other telehealth services through December 31, 2024, allowing the agency additional time

[5] 42 C.F.R. § 410.78 (2001).

[6] Medicare Telemedicine Health Care Provider Fact Sheet, Ctrs. for Medicare & Medicaid Servs. (Mar. 17, 2020), www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

[7] Trump Administration Issues Second Round of Sweeping Changes to Support U.S. Healthcare System During COVID-19 Pandemic, Ctrs. for Medicare & Medicaid Servs. (Apr. 30, 2020), www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid (hereinafter, Second Round Changes).

[8] Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients, Ctrs. for Medicare & Medicaid Servs. (Dec. 1, 2020), www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment.

to evaluate whether to cover those services permanently.[9] States and private health plans also removed many telehealth coverage restrictions. Medicaid programs in all fifty states and the District of Columbia covered some telehealth services prior to the pandemic, but only nineteen states permitted beneficiaries to receive services at home and very few covered audio-only services.[10] During the pandemic, the majority of states issued emergency policies expanding Medicaid telehealth coverage, most permitting beneficiaries to access telehealth in their home and some audio-only telehealth visits. More than forty states already had laws regulating telehealth coverage, though only about half of them required private insurers to cover telehealth services to the same extent as in-person visits (i.e., coverage parity).[11] During the pandemic, at least six additional states required coverage parity, with another dozen states requiring some level of expanded telehealth coverage.[12] Many states also took steps to expand access to audio-only telehealth services for individuals with private insurance, with only three states requiring plans to cover audio-only services prior to the pandemic and an additional eighteen states requiring private plan coverage of audio-only services permanently or temporarily during the pandemic.[13]

B *Payment Parity*

In addition to expanding coverage, payers also increased reimbursement rates for telehealth services. Medicare reimbursed all audio-video telehealth services and most audio-only telehealth services at the same rate as in-person visits (i.e., payment parity).[14] This was extended and is set to expire at the end of 2023.[15] In at least forty-five states, Medicaid adopted payment parity for audio-video and audio-only telehealth visits – reimbursing both in-person and telehealth service at the same or

[9] Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule, Ctrs. for Medicare & Medicaid Servs. (Nov. 1, 2022), www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule (hereinafter, 2023 Medicare Physician Fee Schedule).

[10] Gabriela Weigel et al., Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond, Kaiser Fam. Found. (May 11, 2020), www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/.

[11] Nathaniel M. Lacktman et al., 50-State Survey of Telehealth Commercial Insurance Laws, Foley & Lardner LLP (Feb. 2021), www.foley.com/-/media/files/insights/publications/2021/02/21mc30431-50state-telemed-reportmaster-02082021.pdf; Weigel et al., supra note 10.

[12] State COVID-19 Data and Policy Actions, Kaiser Fam. Found. (Jan. 12, 2022), www.kff.org/report-section/state-covid-19-data-and-policy-actions-policy-actions/.

[13] JoAnn Volk et al., States' Actions to Expand Telemedicine Access During COVID-19 and Future Policy Considerations, The Commonwealth Fund (June 23, 2021), www.commonwealthfund.org/publications/issue-briefs/2021/jun/states-actions-expand-telemedicine-access-covid-19.

[14] Medicare Telemedicine Health Care Provider Fact Sheet, supra note 6; Second Round Changes, supra note 7.

[15] Susan Morse, Telehealth payment parity only good through 2023, Healthcare Finance (Jan. 27, 2023), www.healthcarefinancenews.com/news/telehealth-payment-parity-only-good-through-2023.

comparable rates.[16] At least eighteen states also adopted policies temporarily requiring telehealth payment parity for private health plans.[17] Several states have since made these changes permanent.[18]

C *Licensing*

Regulators temporarily eliminated state licensing requirements preventing telehealth adoption. For most states and Medicare, providers must be licensed in the state where the patient is located. CMS used its waiver authority to waive licensing requirements, permitting providers with out-of-state licenses to practice via telehealth if they met certain requirements.[19] All fifty states and the District of Columbia also waived certain licensing requirements during the pandemic, with some offering a fast track licensure pathway for out-of-state providers.[20] Some of these waivers applied only to doctors, while many others also included nurses, nurse practitioners, physical therapists, other mental health professionals, or inactive or retired licensees.[21] Most of these waivers were temporary, with about thirty state waivers having expired at the end of 2021 and only three remaining in place in April 2023. States have taken further action,

[16] Kathleen Gifford et al., States Respond to COVID-19 Challenges but Also Take Advantage of New Opportunities to Address Long-Standing Issues: Results From a 50-State Medicaid Budget Survey for State Fiscal Years 2021 and 2022, Kaiser Fam. Found. (Oct. 27, 2021), www.kff.org/report-section/states-respond-to-covid-19-challenges-but-also-take-advantage-of-new-opportunities-to-address-long-standing-issues-benefits-and-telehealth/.

[17] Jared Augenstein et al., Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19, Manatt Health (Dec. 16, 2021), www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat.

[18] State Telehealth Laws and Reimbursement Policies Report, Fall 2022, Ctr. for Connected Health Policy (Oct. 2022), www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2022/.

[19] COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, Ctrs. for Medicare & Medicaid Servs., www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf (last updated May 24, 2021).

[20] U.S. States and Territories Modifying Requirements for Telehealth in Response to Covid-19, Fed'n of State Med. Bds., www.fsmb.org/siteassets/advocacy/pdf/states-waiving-licensure-requirements-for-telehealth-in-response-to-covid-19.pdf (last updated Apr. 12, 2023). Licensing across state lines, U.S. Dep't of Health & Human Servs., https://telehealth.hhs.gov/licensure/licensing-across-state-lines (last updated May 11, 2023).

[21] COVID-19 State Emergency Response: Temporarily Suspended and Waived Practice Agreement Requirements, Am. Ass'n of Nurse Practitioners, www.aanp.org/advocacy/state/covid-19-state-emergency-response-temporarily-suspended-and-waived-practice-agreement-requirements (last updated Jan. 18, 2022); State Licensure Exemptions and Requirements for PTs and PTAs During COVID-19, Fed'n of State Bds. of Physical Therapy, www.fsbpt.org/Portals/0/documents/news-events/Jurisdiction_Licensure_Exemptions_Requirements_Waivers_during_COVID-19.pdf (last updated May 8, 2020); COVID-19 State Resources: State Actions on Telebehavioral Health, Am. Counseling Ass'n (Sept. 1, 2021), www.counseling.org/docs/default-source/grad-stu-volunteers/telehealth-updates-by-state_september-2021_final.pdf; US States and Territories Expediting Licensure for Inactive/Retired Licensees in Response to COVID-19, Fed'n of State Med. Bds., www.fsmb.org/siteassets/advocacy/pdf/states-expediting-licensure-for-inactive-retired-licensees-in-response-to-covid19.pdf (last updated Jan. 19, 2022).

however, to ease telehealth licensing requirements, including temporary practice laws, interstate licensing compacts, and telehealth practice licensure (https://telehealth.hhs.gov/licensure/licensing-across-state-lines.).

D *Doctor–Patient Relationships*

While many states permitted the creation of a doctor–patient relationship via telehealth before the pandemic, some required an in-person examination or an existing doctor–patient relationship before allowing the provision of telehealth services. During the pandemic, some states suspended laws requiring a doctor–patient relationship to be formed through an in-person visit.[22] Similarly, Medicare previously required that a telehealth provider had an existing relationship with the patient and had treated the patient in-person within the past three years.[23] CMS waived these requirements for the duration of the COVID-19 public health emergency.[24] Medicare requirements for in-person visits within six months of the first behavioral health encounter and annually thereafter were also waived through December 31, 2024.[25]

E *Prescribing*

Historically, federal laws have prohibited telehealth prescribing of certain controlled substances without an in-person evaluation. Prior to the pandemic, most states required a patient–provider relationship before certain drugs (the list of drugs varies by state) could be prescribed remotely, and in at least fifteen states a physical exam would be required – in person, by live video, or by a referring physician.[26] During the pandemic, however, at least fifteen states issued emergency orders removing such in-person requirements. The Secretary of HHS and the Drug Enforcement Administration (DEA) invoked the "telemedicine exception" of the Controlled Substances Act, which permits health care providers to prescribe controlled substances, including opioids, via a real-time video telehealth visit without a prior in-person visit. The DEA also exercised enforcement discretion to permit prescribing of buprenorphine, an opioid use disorder treatment, over the phone without an in-person or video consultation.[27] While the in-person evaluation requirement remained for new patients being treated with methadone,

[22] U.S. States and Territories Modifying Requirements for Telehealth in Response to COVID-19, supra note 20.

[23] Weigel et al., supra note 10.

[24] Medicare Telemedicine Care Provider Fact Sheet, supra note 6.

[25] Telehealth policy changes after the COVID-19 public emergency, U.S. Dep't Health & Human Servs., https://telehealth.hhs.gov/providers/telehealth-policy/policy-changes-after-the-covid-19-public-health-emergency (last updated June 7, 2023).

[26] Weigel et al., supra note 10.

[27] FAQs: Provision of Methadone and Buprenorphine for the Treatment of Opioid Use Disorder in the COVID-19 Emergency, Substance Abuse & Mental Health Servs. Admin. (Apr. 21, 2020), www.samhsa.gov/sites/default/files/faqs-for-oud-prescribing-and-dispensing.pdf.

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Opioid Treatment Programs were permitted to dispense both buprenorphine and methadone based on a telehealth evaluation, including an audio-only evaluation. Congress since eased telehealth prescribing of buprenorphine by passing the Mainstream Addiction Treatment Act in 2022.[28] The DEA took further steps, announcing proposed permanent rules that would permit telehealth prescribing of buprenorphine and non-narcotic Schedule III, IV, and V controlled substances under certain circumstances, in some cases without an in-person evaluation.[29]

Similarly, Food and Drug Administration (FDA) regulations requiring in-person visits or laboratory tests for the dispensation of certain medications have historically restricted telehealth prescribing. During the pandemic, the FDA exercised enforcement discretion over in-person testing and dispensing requirements for certain medications, but controversially did not initially waive in-person dispensing requirements for mifepristone, part of a medication abortion regimen.[30] While a Maryland federal court issued two injunctions prohibiting the FDA from enforcing in-person requirements for mifepristone, the Supreme Court stayed enforcement of the Court's decision in January 2021, allowing the FDA to continue enforcing the requirements.[31] The FDA under the Biden Administration later lifted these restrictions, first temporarily in April 2021 and then permanently in January 2023, thereby permitting online prescribing of mifepristone as well.[32] The policy change remains controversial, with an ongoing court battle challenging FDA's approval of and safety requirements for mifepristone.[33] This controversy is exacerbated by the Supreme Court's decision in Dobbs v. Women's Whole Health Organization and states' efforts to both protect and restrict access to abortion. While some states permit telehealth to access medication abortions, other states have required in-person visits or in-person dispensing to limit access.[34]

[28] Sheri Doyle & Vanessa Baaklini, President Signs Bipartisan Measure to Improve Addiction Treatment, Pew Charitable Trusts (Dec. 30, 2022), www.pewtrusts.org/en/research-and-analysis/articles/2022/12/30/president-signs-bipartisan-measure-to-improve-addiction-treatment.

[29] Telemedicine Prescribing of Controlled Substances When the Practitioner and the Patient Have Not Had a Prior In-Person Medical Evaluation, 88 Fed. Reg. 12875 (Mar. 1, 2023); Expansion of Induction of Buprenorphine via Telemedicine Encounter, 88 Fed. Reg. 12890 (Mar. 1, 2023).

[30] Mifeprex (mifepristone) Information, US Food & Drug Admin., www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information; Am. Coll. of Obstetricians & Gynecologists v. U.S. Food & Drug Admin., 472 F.Supp.3d 183, 194 (D. Md. 2020).

[31] Food & Drug Admin. v. Am. Coll. of Obstetricians & Gynecologists, 141 S.Ct. 578 (2021).

[32] Alice Miranda Ollstein & Darius Tahir, FDA Lifts Curbs on Dispensing Abortion Pills During Pandemic, Politico (Apr. 12, 2021), www.politico.com/news/2021/04/12/abortion-pills-481092; Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation, US Food & Drug Admin., www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/information-about-mifepristone-medical-termination-pregnancy-through-ten-weeks-gestation (last updated Mar. 23, 2023).

[33] Patricia J. Zettler, Eli Y. Adashi, & I. Glenn Cohen, *Alliance for Hippocratic Medicine v. FDA — Dobbs*'s Collateral Consequences for Pharmaceutical Regulation, 388(10) *New Eng. J. Med.* e29 (1), e29(1–3) (2023).

[34] The Availability and Use of Medication Abortion, Kaiser Fam. Found. (June 1, 2023), www.kff.org/womens-health-policy/fact-sheet/the-availability-and-use-of-medication-abortion/.

F *Privacy*

The Health Insurance Portability and Accountability Act (HIPAA), which sets privacy and security requirements for health care providers and certain other entities handling health information, prohibits providers from communicating with patients or transmitting patient information over most commonly used platforms. In March 2020, HHS announced that during the pandemic it would "exercise enforcement discretion and … waive potential penalties for HIPAA violations against health care providers" delivering telehealth services over common platforms, including FaceTime and Zoom, as long as they were not public-facing.[35] Many states also provided guidance on state health privacy laws for telehealth providers. HHS announced that the discretionary enforcement for HIPAA violations related to telehealth will conclude at the end of the public health emergency, with a 90-day transition period for entities to become compliant.[36]

IV DATA ON TELEHEALTH ADOPTION DURING THE PANDEMIC

These changes and reforms to telehealth regulation, and many others, permitted a massive surge in telehealth adoption during the COVID-19 pandemic. While the week before the pandemic saw only 13,000 Medicare telehealth visits, the last week in April 2020 saw 1.7 million.[37] By the end of 2020, there were 52.7 million Medicare fee-for-service telehealth visits, a sixty-three-fold increase compared to 2019.[38] Medicaid and Children's Health Insurance Program beneficiaries saw a twenty-fold increase in telehealth visits, from six telehealth visits per 1,000 beneficiaries in February 2020 to over 150 telehealth visits per 1,000 beneficiaries in April 2020.[39] From April 2019 to April 2020, private insurance claims for telehealth increased by more than 8,000 percent.[40]

Telehealth provided access to many health care services, making possible treatment that would have otherwise been delayed or prevented by the pandemic. Providers met virtually with patients, over the phone or by videoconference, to

[35] OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency, US Dep't of Health & Human Servs. (Mar. 17, 2020), www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html.

[36] HHS Office for Civil Rights Announces the Expiration of COVID-19 Public Health Emergency HIPAA Notifications of Enforcement Discretion, US Dep't of Health & Human Servs. (April 11, 2023) www.hhs.gov/about/news/2023/04/11/hhs-office-for-civil-rights-announces-expiration-covid-19-public-health-emergency-hipaa-notifications-enforcement-discretion.html.

[37] Seema Verma, Early Impact of CMS Expansion of Medicare Telehealth During COVID-19, Health Affs. Blog (July 15, 2020), www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/.

[38] Samson et al., supra note 2, at 4.

[39] Chu et al., supra note 4, at 1.

[40] Robin Gelburd, Telehealth Growth in April Suggests Continuing Impact of COVID-19, *Am. J. Managed Care* (July 7, 2020), www.ajmc.com/view/telehealth-growth-in-april-suggests-continuing-impact-of-covid19.

provide non-urgent care visits or other routine consultations to manage medical and psychiatric conditions. Among medical specialties, gastroenterology, neurology, endocrinology, and psychiatry saw the greatest telehealth adoption during the pandemic, while obstetrics/gynecology, oncology, ophthalmology, physical therapy, and orthopedics saw the least.[41] More than half of endocrinologists, gastroenterologists, neurologists, pain management physicians, and psychiatrists used telehealth at least once during the COVID-19 pandemic between March and June 2020.[42] Telehealth in pediatrics varied by location and type of provider, with many visits for endocrine, nutritional, and metabolic diseases, and mental and neurodevelopmental disorders.[43]

Telehealth utilization rates varied widely across the country. One study found that between May 20, 2020 and June 16, 2020, 47.6 percent of visits in Massachusetts were via telehealth, compared to only 8.4 percent in South Dakota.[44] The Assistant Secretary for Planning and Evaluation similarly reported that between January and December 2020, the highest use of telehealth by Medicare beneficiaries was in Massachusetts, Vermont, Rhode Island, New Hampshire, and Connecticut, while the least use was in Tennessee, Nebraska, Kansas, North Dakota, and Wyoming.[45] There was also greater telehealth adoption in urban areas, counties with low poverty rates, and areas with a higher COVID-19 prevalence between March and June 2020.[46]

These explosive telehealth utilization rates decreased as the pandemic wore on, but stayed significantly above pre-pandemic levels. After quarantine ended for most people in early May 2020, telehealth use decreased, though it was still about thirty-eight times above the pre-pandemic level.[47] These telehealth rates leveled out during the summer of 2020, plateauing at about 17 percent of all outpatient visits. Some specialties saw significantly higher continued telehealth use, in particular psychiatry and substance use treatment, maintaining telehealth rates at about 50 percent and 30 percent, respectively. Neurology, family medicine, and internal medicine also

[41] NORC at the Univ. of Chi., Changes to Telehealth Policy, Delivery, and Outcomes in Response to COVID-19 11 (Dec. 2020), www.pcori.org/sites/default/files/PCORI-Landscape-Review-NORC-Changes-Telehealth-Policy-Delivery-Outcomes-Response-COVID-19-December-2020.pdf; Sadiq Y. Patel et al., Variation in Telemedicine Use and Outpatient Care During the COVID-19 Pandemic in the United States, 40 *Health Affs.* 349, 353–54 (2021).

[42] Patel et al., supra note 40, at 353.

[43] Alison Curfman et al., Pediatric Telehealth in the COVID-19 Pandemic Era and Beyond, 148 *Pediatrics* e20200477795v (2021); Stormee Williams et al., Pediatric Telehealth Expansion in Response to COVID-19, 9 *Front. Pediatr.* 642089 (2021).

[44] Sadiq Y. Patel et al., Trends in Outpatient Care Delivery and Telemedicine During the COVID-19 Pandemic in the US, 181 *J. Am. Med. Ass'n Intern. Med.* 388, 388–91 (2020).

[45] Samson et al., supra note 2, at 11.

[46] Jonathan P. Weiner et al., In-Person Telehealth Ambulatory Contacts and Costs in a Large US Insured Cohort Before and During the COVID-19 Pandemic, 4 *J. Am. Med. Ass'n Network Open* e212618 (2021).

[47] Oleg Bestsennyy et al., Telehealth: A Quarter-Trillion-Dollar Post-COVID-19 Reality, McKinsey & Co. (July 9, 2021), www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/telehealth-a-quarter-trillion-dollar-post-covid-19-reality.

sustained higher rates of telehealth video visits through March 2021.[48] Other specialties, especially surgical specialties, largely returned to in-person visits.[49]

Despite the decrease in telehealth utilization, the changed landscape endured. Patients and providers alike indicated high satisfaction with telehealth and a desire to continue using telehealth after the pandemic. A May 2020 Press Ganey survey found that 96.3 percent of patients were likely to recommend a telehealth visit with their provider to others.[50] Providers have also reported positive experiences with telehealth. One survey of a large health care system found that clinicians "feel that they are able to not only provide equal quality of care in a video visit and an in-person visit, but also to establish rapport to the same extent via either type of visit."[51]

V TELEHEALTH RISKS AND LIMITATIONS

While the COVID-19 pandemic highlighted telehealth's potential, it also raised several risks and limitations associated with telehealth use, in addition to the challenges discussed above.

A *Disparities in Telehealth Access and Use*

Telehealth aims to improve access to health care, but the experience during the pandemic made it plain that access is not equitable. A major disparity related to telehealth is the "digital divide" – the gap in access to technology, access to Internet coverage, and digital literacy. Lack of access to technology prevents many populations from accessing telehealth. People without a smartphone, computer, or tablet may not be able to use telehealth or may only be able to use audio-only services, which providers largely view as inferior. Older adults, people of color, and low-income populations are less likely to have the technology at home needed for telehealth access.[52] The technology necessary for telehealth, and in some cases the website accessibility of the telehealth platform, pose further challenges for some populations, as many platforms are not accessible for people with disabilities, particularly visual, hearing,

[48] Inst. for Healthcare Pol'y & Innovation, Univ. of Mich., Telehealth Incubator Research Snapshots 8 (Dec. 2021), https://ihpi.umich.edu/sites/default/files/2021-08/Telehealth_Research_Snapshots_Databook_2021.pdf.

[49] Chartis Grp., Telehealth Adoption Tracker (Sept. 8, 2021), https://reports.chartis.com/telehealth_trends_and_implications-2021/.

[50] Press Ganey Special Report: The Rapid Transition to Telemedicine: Insights and Early Trends (2020).

[51] Inst. for Healthcare Pol'y & Innovation, Univ. of Mich., supra note 47, at 37.

[52] Lauren A. Eberly et al., Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic, 3 *J. Am. Med. Ass'n Network Open* e2031640 (2020); Eric T. Roberts & Ateev Mehrotra, Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine, 180 *J. Am. Med. Ass'n Intern. Med.* 1386, 1386 (2020).

or speech impairments, or cognitive disabilities.[53] Many telehealth platforms are only in English, are primarily designed for English speakers, or have limited access to interpreters, preventing effective use for patients with limited English proficiency or who are non-English speaking.[54] The design of telehealth technologies is frequently not made with the specific needs of various populations in mind.[55] Access to Internet coverage is also necessary for telehealth. Half of low-income Americans and a third of rural Americans lack broadband access at home.[56] Digital literacy, or the ability of people to use technologies, also contributes to disparities in telehealth. Older adults in particular have less digital literacy, hindering their ability to use telehealth.[57] Without addressing the digital divide, telehealth may leave certain populations behind, including those already experiencing health disparities.

Consistent with these barriers, studies have shown that people in rural areas, older adults, people with Medicaid, and patients whose preferred language was not English had lower rates of telehealth adoption during the COVID-19 pandemic.[58] Relatedly, older age, Black race, Latinx ethnicity, Medicaid insurance, and lower income were associated with decreased use of telehealth with video and increased use of audio-only telehealth services. While telehealth seeks to promote access to health care, it may be exacerbating existing health disparities.

B *Telehealth Appropriateness and Effectiveness Across Health Care Contexts*

There are also concerns about telehealth's appropriateness and effectiveness in different health care contexts. Some benefits of telehealth are broadly accepted, including "refilling prescriptions, treating low-severity symptoms, and counseling for mental health."[59] Telestroke care has been used for decades and is an effective, life-saving tool.[60] A systematic review indicated that outcomes of telemental

[53] Rupa S. Valdez et al., Ensuring Full Participation of People with Disabilities in an Era of Telehealth, 28 *J. Am. Med. Informatics Ass'n* 389, 390 (2021); Carli Friedman & Laura VanPuymbrouck, Telehealth Use by People With Disabilities During the Pandemic, 13 *Int'l J. Telerehabilitation* (2021).

[54] Nicole Wetsman, Telehealth Wasn't Designed for Non-English Speakers, Verge (June 4, 2020), www.theverge.com/21277936/telehealth-english-systems-disparities-interpreters-online-doctor-appointments.

[55] Kimberly Noel & Brooke Ellison, Inclusive Innovation in Telehealth, 3 *npj Digital Med.* 89 (2020).

[56] Utsha Khatri et al., These Key Telehealth Policy Changes Would Improve Buprenorphine Access While Advancing Health Equity, Health Affs. Blog (Sept. 11, 2020), www.healthaffairs.org/do/10.1377/hblog20200910.498716/full/; Mark E. Dornauer & Robert Bryce, Too Many Rural Americans Are Living in the Digital Dark. The Problem Demands a New Deal Solution, Health Affs. Blog (Oct. 28, 2020), www.healthaffairs.org/do/10.1377/hblog20201026.515764/full/.

[57] Kenneth Lam et al., Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic, 180 *J. Am. Med. Ass'n Intern. Med.* 1389, 1389–90 (2020).

[58] Patel et al., supra note 40, at 352, 357; Eberly et al., supra note 51; Loretta Hsueh et al., Disparities in Use of Video Telemedicine Among Patients With Limited English Proficiency During the COVID-19 Pandemic, 4 *J. Am. Med. Ass'n Network Open* e2133129 (2021).

[59] Kurt R. Herzer & Peter J. Pronovost, Ensuring Quality in the Era of Virtual Care, 325 *J. Am. Med. Ass'n* 429, 429 (2021).

[60] Mehrotra et al., supra note 1.

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health relating to assessment and treatment of mental health conditions were not significantly different when compared with in-person care.[61] The same review found that care delivered by telerehabilitation was generally equivalent to or yielded better outcomes than in-person care. Telehealth has also been effective in detecting post-operative complications related to appendectomies and colorectal surgeries.[62] Additionally, a study also found that in the obstetric field, telehealth interventions improved outcomes related to smoking cessation and breastfeeding, and decreased the need for high-risk obstetric monitoring office visits while maintaining maternal and fetal outcomes.[63] Telehealth was also found likely to yield clinical improvements in nutrition management for older adults living at home when compared to usual care or no intervention.[64]

Alongside the benefits of telehealth, there also exist some drawbacks to using it as an delivery method. Naturally, there are limitations in which tests, assessments, and examinations can be accomplished during a telehealth visit without a patient having additional medical technologies at their disposal. For example, assessments of blood pressure and cholesterol during telehealth primary care visits decreased during the COVID-19 pandemic.[65] Further, many types of care, even if they can be initiated over telehealth, necessitate subsequent in-person visits. Between 10 and 20 percent of patients require an in-person biopsy after a telehealth dermatology visit and 38 percent of patients receiving a diabetic retinopathy screening via telehealth require an in-person follow-up.[66] Another study showed that patients using direct-to-consumer telemedicine for diagnosis of acute respiratory infections were more likely to have a repeat related visit within seven days than similar patients who visited their providers in person.[67] Patients may be seeking this follow-up care because they were directed to, due to a worsening of their symptoms, or due to concerns about the inability to conduct a physical examination or the quality of care provided by a telemedicine visit. These issues of proximity may also have impacts on the accuracy of diagnosis and consequently on the quality of treatment. For example, a study reported

[61] Erin Shigekawa et al., The Current State of Telehealth Evidence: A Rapid Review, 27 *Health Affs.* 1975, 1978 (2018).

[62] Asim Kichloo et al., Telemedicine, The Current COVID-19 Pandemic and the Future: A Narrative Review and Perspectives Moving Forward in the USA, *Fam. Med. Community Health* 8(3): e000539 (2020).

[63] Nathaniel DeNicola et al., Telehealth Interventions to Improve Obstetric and Gynecologic Health Outcomes, 135 Obstetric Gynecology 371 (2020).

[64] Shigekawa et al., supra note 60, at 1980.

[65] Herzer & Pronovost, supra note 58, at 429.

[66] Lori Uscher-Pines & Ateev Mehrotra, Telehealth Alone Will Not Increase Health Care Access for the Underserved, Health Affs. Blog (Dec. 15, 2016), www.healthaffairs.org/do/10.1377/hblog20161215.057859/full/.

[67] Kathleen Yinran Li et al., Direct-To-Consumer Telemedicine Visits for Acute Respiratory Infections Linked to More Downstream Visits, 40 *Health Affs.* 596 (2021).

that in-person dermatology performed better for diagnostic accuracy than teledermatology; within this, a higher diagnostic concordance was found between in-person dermatology and live video as compared to asynchronous communications (submitting data for review by a provider at a later time).[68] A 2018 study examining patients seeking care for a sore throat found that telemedicine exhibited poor agreement with the in-person physical examination on the primary outcome of tonsil size, but exhibited moderate agreement on coloration of the palate and cervical lymphadenopathy, and suggested that physical examination likely remained an important part of the diagnostic process.[69]

While telehealth has been seen to be successful during the pandemic overall, it is not effective or appropriate in all health care contexts. Further research is required to determine how the efficiency of telehealth can be maximized to discern those specialties and services for which telehealth is suited and those for which it is not ideal. Research comparing the impact of in-person visits and telehealth visits on health outcomes will also prove very valuable.

C *Telehealth Utilization and Spending*

Furthermore, there has been debate as to whether increased telehealth coverage in the long term will drive up health care utilization and, in turn, health care spending. The convenience of telehealth may promote excessive, unnecessary utilization; as such, some studies have indicated that telehealth coverage expansions would increase overall health spending.[70] There is conflicting evidence as to whether this has been the case in practice. One study of ambulatory visits between October 1, 2019 and April 30, 2021 at a large New England health care system found that adopting telehealth did not increase the overall volume of visits and that most telehealth visits were substitutive, not additive.[71] This evidence must be considered in light of the fact that such care was sought during an ongoing pandemic, and it is unclear where telehealth services will be substitutive or additive in the absence of these circumstances. For example, a study of Blue Cross Blue Shield of Michigan patients between 2011 and 2017 found telehealth visits for all conditions except mental health were associated with a higher rate of subsequent visits and increased health care utilization.[72]

[68] Shigekawa et al., supra note 60.

[69] Moneeb Akhtar et al., Telemedicine Physical Examination Utilizing a Consumer Device Demonstrates Poor Concordance with In-Person Physical Examination in Emergency Department Patients with Sore Throat: A Prospective Blinded Study, 24 *Telemed. J. e-Health* 790 (2018).

[70] Mehrotra et al., supra note 1.

[71] Kori S. Zachrison et al., Changes in Virtual and In-Person Health Care Utilization in a Large Health System During the COVID-19 Pandemic, 4 *J. Am. Med. Ass'n Network Open* e2129973 (2021).

[72] Xiang Liu et al., Comparison of Telemedicine Versus In-Person Visits on Impact of Downstream Utilization of Care, 27 *Telemed. J. e-Health* 1099, 1099 (2021).

D *Telehealth Fraud*

From the beginning of the pandemic, HHS recognized the potential for health care fraud in telehealth, especially as its use increased. To mitigate provider risk and incentivize telehealth adoption, HHS allowed providers to reduce or waive patient copayments for telehealth services during the COVID-19 pandemic, which typically would violate the Anti-Kickback Statute.[73] While this eased the quick transition to telehealth, it did not prevent fraud and abuse in the growing telehealth market. The relaxed regulatory environment increased the risk of upcoding (billing for more expensive services or more time than was spent with the patient), misrepresenting the services provided, and billing for services not rendered. Studying telehealth use during the first year of the pandemic, the HHS Office of the Inspector General found 1,714 providers – receiving $127.7 million in Medicare fee-for-service payments – that posed a high risk of fraud, waste, or abuse of telehealth services.[74] Some large telehealth fraud schemes have involved telehealth providers billing for consultations that did not occur and receiving bribes to order unnecessary testing, durable medical equipment, and pain medications, sometimes with no or limited patient interaction. Two such cases brought by the Department of Justice in 2020 and 2021 alleged $4.5 billion and $1.1 billion in losses to Medicare, respectively.[75]

VI THE FUTURE OF TELEHEALTH

Steps have already been taken to secure telehealth's future place in the US health care system. Some reforms have already been implemented, while many other proposals at the federal and state levels remain pending.

A *Federal and State Reforms and Proposals*

Many of the changes implemented during the pandemic have been made permanent. In 2021, CMS permanently added several telehealth services to its list of

[73] Medicare Telemedicine Health Care Provider Fact Sheet, supra note 6.

[74] Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks, US Dep't of Health & Human Servs. Office of the Inspector General (Sept. 2022), https://oig.hhs.gov/oei/reports/OEI-02-20-00720.pdf.

[75] National Health Care Fraud and Opioid Takedown Results in Charges Against 345 Defendants Responsible for More Than $6 Billion in Alleged Fraud Losses, US Dep't of Just. (Sept. 30, 2020), www.justice.gov/opa/pr/national-health-care-fraud-and-opioid-takedown-results-charges-against-345-defendants; National Health Care Fraud Enforcement Action Results in Charges Involving Over $1.4 Billion in Alleged Losses, US Dep't of Just. (Sept. 17, 2021), www.justice.gov/opa/pr/national-health-care-fraud-enforcement-action-results-charges-involving-over-14-billion.

Medicare-covered services, including group psychotherapy and psychological and neuropsychological testing.[76] In 2022, CMS authorized Medicare payments for telehealth services furnished "for purposes of diagnosis, evaluation or treatment of a mental health disorder" on a permanent basis. CMS also expanded the ability of Opioid Treatment Programs to provide counseling and therapy services using audio-only telehealth, while Substance Abuse Mental Health Services Administration extended the rules permitting telehealth prescribing of methadone by Opioid Treatment Programs.[77] The FDA permanently removed mifepristone's in-person dispensing requirements in January 2023.[78] Since March 2021, at least 25 states have passed laws expanding access to telehealth, including allowing telephone visits and requiring telehealth services be accessible for people with disabilities, older adults, and people with limited English proficiency.[79] Twenty-one states have adopted payment parity as of May 2023, with an additional seven states having conditional payment parity.[80] Arkansas passed legislation allowing providers to establish a relationship and treat patients in an audio-video or audio-only telehealth visit and to prescribe non-controlled substances.[81] At least nine states have permanently allowed for audio-only telehealth visits in Medicaid.[82] Five new states joined the Interstate Medical Licensure Compact, easing licensing barriers for telehealth providers in those states.[83]

Other changes have not yet been made permanent, although several telehealth policy proposals have been made at the federal and state levels. Multiple bills have been introduced in Congress to remove Medicare's geographic restrictions on

[76] Calendar Year (CY) 2021 Medicare Physician Fee Schedule Final Rule, Ctrs. for Medicare & Medicaid Servs. (Dec. 2, 2020), https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf.

[77] Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule, Ctrs. for Medicare & Medicaid Servs. (Nov. 2, 2021), www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule; Methadone Take-Home Flexibilities Extension Guidance, Substance Abuse Mental Health Servs. Admin., www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/methadone-guidance (last updated Nov. 18, 2021).

[78] Information about Mifepristone for Medical Termination of Pregnancy Through Ten Weeks Gestation, supra note 31.

[79] JoAnn Volk, Madeline O'Brien, & Christina L. Goe, State Telemedicine Coverage Requirements Continue to Evolve, The Commonwealth Fund (Dec. 20, 2022), www.commonwealthfund.org/blog/2022/state-telemedicine-coverage-requirements-continue-evolve.

[80] Jared Augenstein & Jacqueline Marks Smith, Executive Summary: Tracking Telehealth Changes State-by-State in Response to COVID-19, Manatt (June 9, 2023), www.manatt.com/insights/newsletters/covid-19-update/executive-summary-tracking-telehealth-changes-stat.

[81] H.B. 1063, 93rd Gen. Assemb., Reg. Sess. (Ark. 2021).

[82] Jacquelyn Rudich et al., State Medicaid Telehealth Policies Before and During the COVID-19 Public Health Emergency: 2022 Update, U.S. Dep't of Health & Human Servs. Ass't Secretary for Planning & Evaluation (Nov. 22, 2022), https://aspe.hhs.gov/sites/default/files/documents/190b4b132f984db14924cbad00d19cce/Medicaid-Telehealth-IB-Update-Final.pdf.

[83] Press Releases, Interstate Medical Licensure Compact, www.imlcc.org/news/press-releases-and-publications/ (last visited Jan. 24, 2021).

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telehealth coverage.[84] Other bills have sought to expand access to telehealth for specific types of health care services. The Women's Health Protection Act of 2023 would protect providers' ability to deliver and patients' ability to access telehealth medication abortion services.[85] The Expanding Access to Mental Health Services Act would allow Medicare to permanently cover behavioral health counseling services provided via audio-only telehealth.[86] Many states have also proposed legislation to expand coverage of audio-only telehealth services, to require coverage parity and payment parity for telehealth services, and to provide the cross-border provision of telehealth services. Other states have let their temporary waivers expire or actively sought to reel back their telehealth expansions; for example, a New Hampshire bill was introduced seeking to end audio-only coverage and telehealth payment parity.[87]

Still other changes implemented during the pandemic have gone unaddressed. No reforms have been made to HIPAA to expand technologies that can be used for telehealth. Although there has been an increase in telehealth fraud enforcement, no changes have been made to the current regulatory scheme to prevent telehealth fraud in the first place.

B *Uniform Law Commission Draft Legislation*

The Uniform Law Commission, the largest state law-drafting organization in the country, approved the Uniform Telehealth Act in July 2022 to aid states in developing their own telehealth legislation.[88] The November 18, 2021 draft of the Telehealth Act explained that the Committee sought to capture two broad goals with the model legislation: to emphasize parallels between the delivery of telehealth services and in-person traditional services; and to establish a registration system for out-of-state practitioners to reduce existing licensing barriers. As approved, the Act sets forth the circumstances under which a practitioner may provide telehealth services in a state. It does not, however, engage with the critical questions of coverage parity or payment parity. Further, passed in the wake of *Dobbs v. Women's Whole Health Organization*, the Act poses potential obstacles for the telehealth consultation and prescribing across state lines on matters relating to reproductive choice. This has led some former supporters of the idea of uniform telehealth legislation to object to the finalized version without further amendment. The future of the Uniform Telehealth Act remains uncertain and thus far no states have enacted it.

[84] To amend title XVIII of the Social Security Act to remove geographic requirements and expand originating sites for telehealth services, H.R. 134, 118th Cong. (2023); Fair Care Act of 2022, H.R.8588, 117th Cong. (2022); Telehealth Modernization Act, S. 368, 117th Cong. (2022).
[85] Women's Health Protection Act of 2023, H.R. 12, 118th Cong. (2023).
[86] Expanding Access to Mental Health Services Act, H.R. 635, 118th Cong. (2023).
[87] H.B. 602, 2021 Leg., Exec. Sess. (N.H. 2021).
[88] Uniform Telehealth Act (Unif. Law Comm'n 2022).

VII CONCLUSION

The telehealth landscape has been permanently transformed by the COVID-19 pandemic. Providers are expanding their telehealth services. Companies and health systems are experimenting with new telehealth innovations, from using artificial intelligence to remotely adjust a patient's insulin dose to using drones with cameras to consult with patients in their home while delivering medications or medical supplies. The telehealth market is growing, with non-traditional companies such as Walmart entering the telehealth space.

But for telehealth's success to continue in the future, regulatory reforms are needed. The changes implemented to permit telehealth adoption are largely temporary, with some having already expired and others set to expire at the end of the declared COVID-19 public health emergency. Further, there are risks and limitations with telehealth, resulting in greater health disparities and potential fraud and abuse. Several telehealth policy proposals have already been made at the federal and state levels, considering issues from coverage and payment parity to cross-border provision of care to expanding the locations where Medicare and Medicaid patients can receive telehealth services. Additional reforms should take into account the challenges observed during the COVID-19 pandemic and seek to promote telehealth's future success, and continued research is needed to determine the proper role of telehealth in the US health care system.

Going forward, the lessons from the pandemic should inform future policymaking so telehealth can continue to thrive and promote access to health care for all.