Telehealth in the COVID-19 Pandemic

Cason D. Schmit, JD; Johnathan Schwitzer; Kevin Survance; Megan Barbre; Yeka Nmadu, MBBS; and Carly McCord, PhD, Texas A&M University

SUMMARY. The COVID-19 pandemic highlights the value of telehealth as a public health measure by permitting health care at a distance, keeping providers and patients safe while enabling health care in strained health systems. This Chapter explores how states have acted through legislative, regulatory, and executive actions to leverage telehealth in the COVID-19 response. Congress passed three new pieces of federal telehealth legislation in response to COVID-19: The Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Telehealth Services During Certain Emergency Periods Act, and the Families First Coronavirus Response Act. These new federal laws provide additional funding and regulatory flexibility for telehealth under the Medicare and TRICARE programs. Additionally, 27 states have new telehealth authorities in response to COVID-19. These new state authorities generally expand telehealth by removing regulatory barriers, authorizing more telehealth providers or telehealth modalities, and expanding telehealth coverage. This Chapter includes a number of recommendations for policymakers including addressing inequities, eliminating telehealth barriers (e.g., location requirements), authorizing additional providers and telehealth modalities, and expanding telehealth coverage.

Introduction

Defined as "the use of electronic information and telecommunication technologies to support long-distance clinical health care," telehealth is touted as a tool to improve health care access by connecting patients with providers at a distance (HRSA, 2018; Speyer et al., 2018). Telehealth is particularly useful in rural or health care shortage areas where patients have difficulty finding a provider in their area. Telehealth also shows promise as an effective and cost-saving form of health care delivery.

Nevertheless, telehealth has challenges compared to traditional care. Telecommunication does not permit physical exams or use of some special equipment and creates technological and security issues for providers and patients (Balestra, 2018). Technology access, digital literacy, and reliable internet coverage are major barriers to telehealth that are experienced disproportionately among certain populations, particularly the elderly, persons of color, and individuals with low socioeconomic status (Velasquez & Mehrotra, 2020). Consequently, there are known disparities in telehealth usage. Unfortunately, the populations with disproportionately high telehealth barriers are many of the same populations at the highest risk of COVID-19.

More troubling, while telehealth visits have increased substantially during the COVID-19 emergency, disparities are widening. Evidence suggests that the proportion of the elderly, persons of color, and individuals with low socioeconomic status receiving telehealth services has actually decreased significantly during the COVID-19 response (Nouri et al., 2020). This worrisome evidence suggests that health inequities among these populations are likely to increase. These inequities might even be exacerbated if health care systems and providers prioritize limited telehealth capacity on those patients that can provide the highest reimbursement rates (i.e., those with private health insurance) (Clair et al., 2020)

These and other issues provide justification for governmental regulation to promote safe and effective health care. State and federal laws, however, can be both facilitators and barriers to telehealth.

Licensure and scope of practice laws determine whether a health care provider can provide telehealth services (CCHP, 2020; Schmit et al., 2019). For example, some states restrict the ability of non-physician providers (e.g., nurse practitioners, licensed professional counselors) to provide telehealth services. Interstate scope of practice variation is cited as a major barrier to interjurisdictional telehealth (Sodhi, 2020).

Laws regulating Medicare, Medicaid, and private health plans establish rules and requirements for paying for telehealth services, fundamentally shaping service delivery (Mehrotra et al., 2017; Sodhi, 2020). Some states permit Medicaid and private health plans to reimburse telehealth services at lower rates than comparable

in-person services while other states require payment parity between telehealth and in-person services. Parity laws provide a monetary incentive for providers to offer telehealth services, but prevent health care payers from taking advantage of telehealth's cost-saving potential (Turner Lee et al., 2020). Some laws impose barriers for new telehealth patients (e.g., requiring an initial in-person visit). Restrictive telehealth payment laws are cited as a barrier to telehealth adoption (Mehrotra et al., 2017). However, other laws can facilitate telehealth use (e.g., laws requiring private health plans to cover telehealth) (Adler-Milstein et al., 2014; Sodhi, 2020).

Laws also define which telecommunication modalities qualify as a telehealth service both for practice and reimbursement (Bagchi, 2020). Prior to COVID-19, all states permitted some form of synchronous (i.e., real-time) video telehealth (CCHP, 2020). Asynchronous (i.e., store-and-forward) telehealth was less commonly permitted by states, and audio-only communication was rarely permitted among states (see Iowa, Maine, Oregon). Laws that limit telehealth services to synchronous video communications challenge patients without access to technology (e.g., computer, smart phone) or broadband internet access (Bagchi, 2020).

In the context of the COVID-19 pandemic, telehealth has transformed from a tool promoting access and convenience to a vital public health measure. COVID-19 did not magically erase the existing endemic health issues, and it certainly exacerbated many (Sherrard-Smith et al., 2020; Stop TB Partnership, 2020). Patients with chronic conditions still need prescriptions and continuing care. Patients with acute conditions still need access to care and consultation. Mental and behavioral health issues still need attention and may be magnified by increased isolation. When preventative health care services are not utilized or accessible, the system is forced to respond to emergencies, progressive disease states, and skyrocketing costs.

For many governments, telehealth became a tool to promote physical distancing, enabling providers to see patients and enabling patients to seek care without exposing themselves or others to infection risk. Consequently, telehealth is a critical tool for enabling the continued delivery of health care services while simultaneously mitigating COVID-19 risks.

Policy decisions to expand telehealth also have economic drivers. Stay-at-home orders and restrictions on some procedures drastically reduced patient volumes for many health care providers. Telehealth provided a means to continue providing health care services while minimizing financial losses. Similarly, laws limiting patient out-of-pocket expenses for telehealth services might encourage patients to continue to seek needed services in a new way (i.e., telehealth) during the pandemic.

As policymakers make changes to telehealth laws to respond to the COVID-19 emergency, it is essential that these new authorities clearly communicate what is and is not permitted. Emergency response challenges both policymakers and health care providers. It can be difficult to understand what legal authorities must be added or removed in order to respond appropriately to a rapidly evolving emergency. In some cases, new telehealth legal provisions created ambiguity and uncertainty for health care providers. For example, Oklahoma Executive Order 2020-13 attempted to remove a telehealth barrier for new patients by removing a requirement for a preexisting patient relationship but kept the patient relationship requirement for prescribing controlled substances. In fact, Oklahoma's laws did not have a general requirement for a preexisting relationship; the requirement only applied to prescribing controlled substances. Subsequent amended executive orders clarified this provision, rendering the entire provision pointless. Similarly, a number of states issued executive orders allowing providers to use telehealth or to use a new mode of telehealth (e.g., store-and-forward) that was already permitted in existing authorities. Ambiguity in new emergency authorities creates doubt for health care providers and might make them more reluctant to begin offering new telehealth services or telehealth through new modalities. Clarity is especially important for providers hesitant to invest the time, energy, and monetary resources to identify new technology and create new workflows to offer new telehealth services without any long-term policy guarantees post-COVID-19.

Assessment

Federal Actions

The federal government enacted three new pieces of legislation relating to telehealth in response to COVID-19: The Coronavirus Aid, Relief, and Economic Security (CARES) Act; Telehealth Services During Certain Emergency Periods Act of 2020 (passed as part of the Coronavirus Preparedness and Response Supplemental Appropriations Act); and the Families First Coronavirus Response Act.

The Telehealth Services During Certain Emergency Periods Act of 2020 (later amended by the Families First Coronavirus Response Act and the CARES Act) provides the secretary of Health and Human Services (HHS) the authority to waive or modify Medicare requirements for telehealth services provided during the COVID-19 emergency period.

The CARES Act, the most substantial federal telehealth legislation in response to COVID-19, has a number of provisions that affect telehealth services. This Act introduced new telehealth grants and appropriations, including providing $200 million to the Federal Communications Commission to remove some technical barriers to telehealth utilization by supporting telecommunications and information services and supplying needed devices and equipment; $1 billion to Indian Health Services, some of which can be used to increase telehealth access and use in tribal communities; and $27 billion to the Public Health and Social Services Emergency Fund for the COVID-19 response, including telehealth. Section 3212 of the CARES Act also expanded eligibility for some existing grants, including adding substance abuse disorder treatment as an eligible telehealth application and permitting for-profit entities to apply for telehealth grants.

The CARES Act also contains a number of provisions that permit specific telehealth applications. For example, Section 3706 of the CARES Act allows telehealth to be used in place of a face-to-face

encounter when certifying a patient for hospice care. The Act also expands tele-mental health services to veterans (prioritizing high-risk veterans), and requires the U.S Department of Veterans Affairs (VA) to provide telehealth capabilities to case managers for homeless veterans.

Congress also included a number of provisions within the CARES Act to create regulatory flexibility for telehealth in respect to the Medicaid program requirements. For example, Section 3704 of the CARES Act promotes the use of telehealth in Federally Qualified Health Centers and includes a special payment rule that ties payment amounts to the national average payments for comparable services. Additionally, Section 3701 of the CARES Act allows High Deductible Health Plans (HDHP) (regulated by the Internal Revenue Service under the Affordable Care Act) to provide coverage for telehealth services without a deductible without losing their status as a HDHP. The Centers for Medicare and Medicaid Services (CMS) has used its Section 1135 waiver authority to expand telehealth coverage and is using a subregulatory process to make coverage changes (CMS, 2020a, 2020b; I. Lee et al., 2020). CMS revised existing Medicare requirements for patient supervision to permit the use of telehealth in place of in-person visits (CMS, 2020a, 2020b). CMS expanded access to telehealth services by temporarily lifting the previously restrictive location requirements, and permitting beneficiaries to receive telehealth in any location, including their homes. Additionally, CMS authorized more health care providers and more telehealth services to be reimbursed via Medicare, including physical therapy, occupational therapy, and speech pathology services (CMS, 2020a, 2020b).

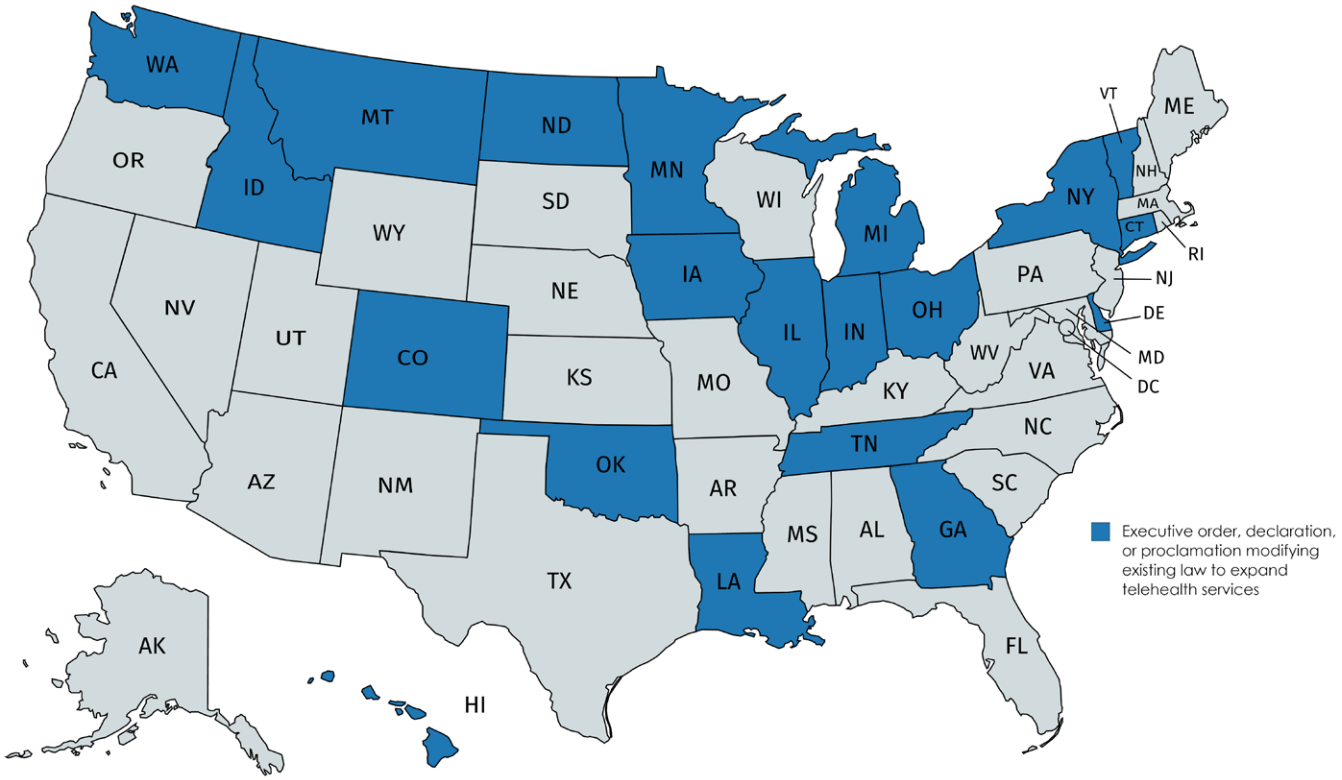
Regulatory amendments to the TRICARE program make telehealth more available, including permitting telehealth services over the phone and waiving out-of-pocket expenses for telehealth (i.e., copayments and deductibles). Similarly, the VA promulgated a regulation permitting home visits to occur via telehealth.

On March 20, 2020 the Office of Civil Rights (OCR) in HHS announced that it was not going to enforce the Health Insurance Portability and Accountability Act (HIPAA) violations against providers using telehealth in "good faith" during the COVID-19 emergency. This announcement gave providers without existing telehealth platforms the freedom to use publicly available telecommunication platforms (e.g., Zoom, Apple FaceTime, Google Hangouts) so long as the platform was not public facing (e.g., Twitter, TikTok, Facebook Live). This move aimed to give health care providers leeway to adapt to a rapidly changing environment without fear that they would face HIPAA's steep penalties. Still, providers wary of telehealth security and privacy pre-COVID-19 might not be assuaged by the OCR decision. Without guarantees of long-term allowances for less secure platforms, providers may be hesitant to make significant (and often costly) changes in their practice or organization.

State Actions

As of May 18, 2020, 27 states implemented new authorities relating to telehealth in response to COVID-19. Five states enacted new legislation (ID, MI, PA, VT, WA), nine states promulgated emergency regulations (CO, IL, LA, NV, NY, OH, OR, TX, WA), and 23 states issued an executive order, declaration, or proclamation relating

Figure 16.1. States with executive orders, declarations, or proclamations modifying existing laws to expand telehealth.



to telehealth in response to COVID-19 (AR, CO, CT, DE, GA, HI, ID, IL, IN, IA, LA, MI, MN, MT, NH, NJ, NY, ND, OH, OK, TN, VT, WA). Twenty states had executive orders, declarations, or proclamations modifying existing laws to expand telehealth (Figure 16.1).

State Actions Addressing Barriers to Telehealth Access and Care. Eleven states expressly encouraged telehealth use (Table 16.1). Ten states removed telehealth barriers for new patients (e.g., prior in-person visit requirements) (AR, CT, DE, HI, LA, MI, MN, MT, NY, OH). Seven states authorized prescribing controlled substances via telehealth without a prior in-person encounter. Four states expanded acceptable telehealth locations to permit providers and patients to interact from a safe location (e.g., their homes), supporting physical-distancing public health measures.

State Actions Addressing Telehealth Coverage and Cost. States can address telehealth financial barriers by requiring health care coverage of appropriate services and reducing out-of-pocket expenses. Expanding telehealth coverage and reducing out-of-pocket expenses incentivizes telehealth and mitigates exacerbating existing and emerging health issues during the COVID-19 response. Seven states expanded Medicaid coverage, 14 states expanded private health insurance coverage, and four states expanded workers' compensation coverage for telehealth services (Figure 16.2). Eliminating out-of-pocket expenses also helps providers rapidly implement telehealth services because collecting copays at a distance requires new infrastructure and workflows. These demands may discourage organizations from offering new telehealth services. Moreover, incentivizing telehealth usage may drive down health care costs by normalizing a cost-effective health care service. Two states have acted to limit Medicaid out-of-pocket expenses, and seven states have limited private insurance out-of-pocket expenses for telehealth services (Figure 16.3).

Prior to COVID-19 many states had adopted parity laws requiring payment for telehealth services at the same amount as comparable in-person services. There are arguments for and against requiring telehealth parity (e.g., promoting telehealth versus limiting telehealth's cost-saving potential). During the COVID-19 response, some health care providers are seeing precipitous decreases in patient volumes with substantially reduced revenues. Requiring telehealth parity has the dual function of encouraging telehealth adoption by providers and helping providers weather the current financial challenges (Shachar et al., 2020). In response to COVID-19, states added legal authorities requiring telehealth parity for Medicaid (MT, NH, OR) and workers' compensation (CO, TN, TX). Seven states added legal authorities requiring parity for private health plans (CO, IA, MT, NH, TX, VT, WA); however, all these states had some form of parity prior to the COVID-19 response (CCHP, 2020).

Telehealth Modalities. Strict telehealth technology requirements pose inequitable burdens on at-risk populations without access to a device capable of synchronous video communication. Without more accessible modes of telehealth (i.e., telephone, email), some populations will lose health care access during the COVID-19 response, exacerbating health inequities and forcing care in riskier health care contexts (e.g., emergency rooms).

Table 16.1: State Actions Relating to the Use of Telehealth in the Response to COVID-19

STATE	ENCOURAGED TELEHEALTH	EXPANDED TELEHEALTH LOCATIONS	CONTROLLED SUBSTANCES RX AUTHORIZED
AR			
CO			
CT		HC	
DE			
GA			
HI			Yes
ID			
IL	Yes		
IN	Yes		Yes
IA			Yes
LA	Yes		Yes
MI	Yes		Yes
MN	Yes		
MT	Yes	PT, HC	
NV			
NH	Yes	PT	
NJ	Yes		Yes
NY			
ND			
OH		PT	
OK	Yes		
OR			
PA			
TN	Yes		Yes
TX			
VT			
WA	Yes		

PT - Indicates expanded telehealth locations for patients

HC - Indicates expanded telehealth for health care providers

Figure 16.2. States Expanding Telehealth Coverage in Response to COVID-19

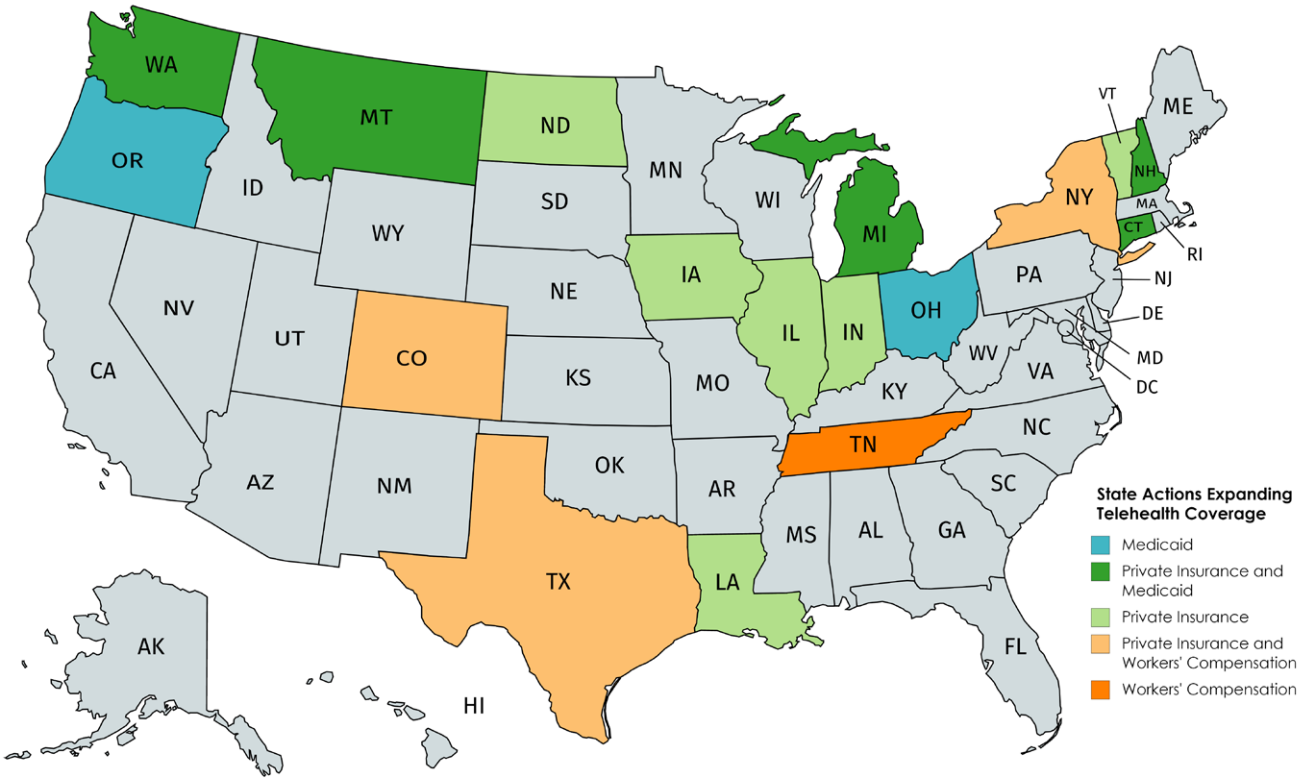
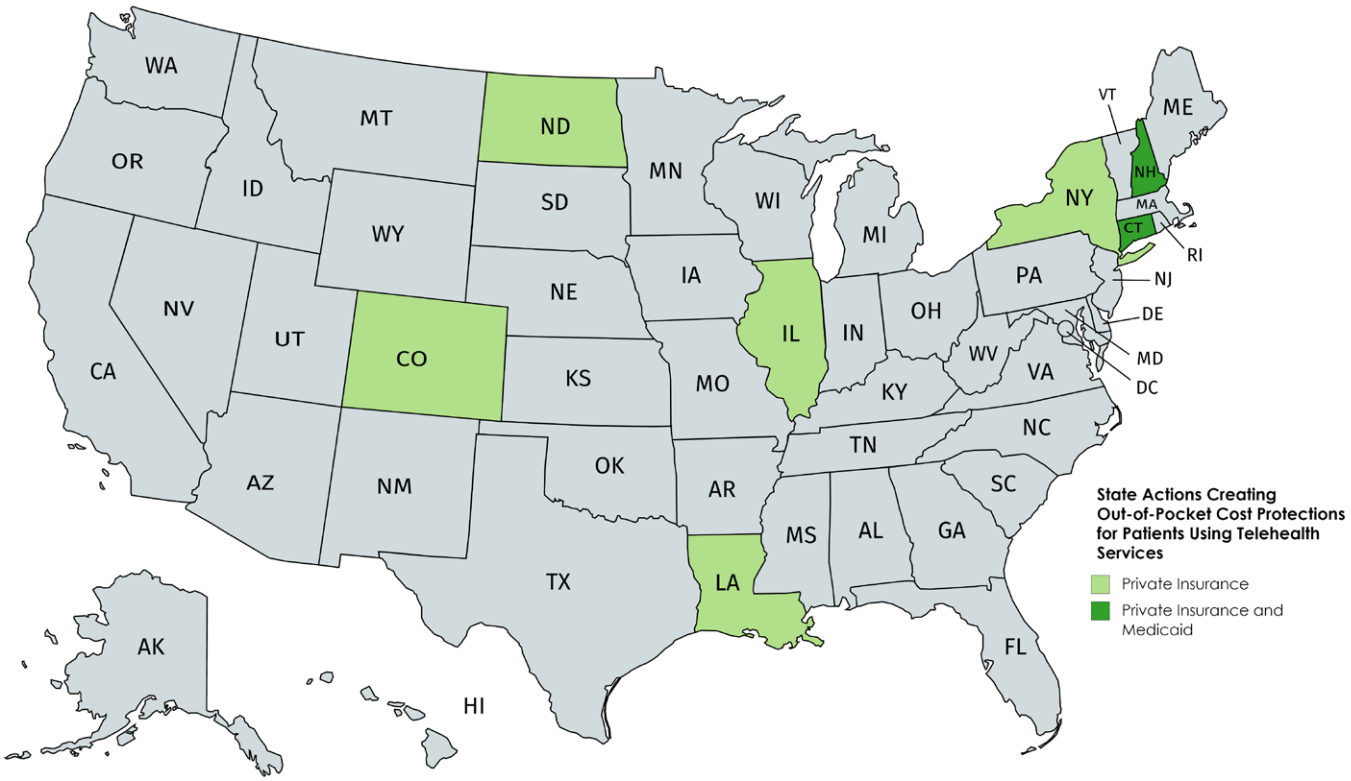


Figure 16.3. State actions creating out-of-pocket cost protections for telehealth services



In response to COVID-19, 16 states expanded permissible telehealth modalities. Eleven added asynchronous methods (CO, CT, DE, IL, IN, MI, MT, NH, OH, OR, VT); 15 added audio-only (e.g., phone) communications (CO, CT, DE, HI, IL, IN, IA, LA, MI, MT, NH, ND, OH, OR, VT); six added text or email communications (CO, MT, NH, OH, OR, VT); and six states added broad permissive language for "other" modalities (CO, IL, MT, NH, NJ, OR) (Table 16.2).

Telehealth Providers. Fourteen states have new authorities that describe or expand the provider types that can provide telehealth (Table 16.2), although many were redundant to existing laws.

There is a strong argument that states should permit any telehealth service that can meet the same standard of care as the comparable in-person service. In the context of COVID-19 – where in-person visits pose additional risks for providers and patients and delaying care exacerbates health issues – states should consider permitting telehealth services where providers can meet an acceptable level of care. In determining acceptable levels of care, policymakers should consider the risk of harm from a comparable in-person visit and risk of harm from delaying the service until after the COVID-19 emergency.

Interjurisdictional Telehealth. State variation in scope of practice and licensure regulations impedes interjurisdictional telehealth practice. Minimizing this barrier will enable providers to quickly mobilize to provide care in new jurisdictions stressed by COVID-19.

Fifteen states expanded the authority to provide telehealth across state lines. Three states (DE, NH, OH) gave in-state providers the authority to provide telehealth to out-of-state patients. Fourteen states granted out-of-state health care professionals authority to provide telehealth to in-state patients, including out-of-state primary care providers (HI, IA), specialists (CT, IA), mental or behavioral health providers (CO, CT, HI, IA, MN), and physical, occupational, or speech therapists (CT, IA). Nine states (DE, GA, LA, MI, MT, NH, ND, OK, TN) provided a broad authorization for out-of-state providers (e.g., "licensed health professionals in good standing").

Table 16.2. State Actions Expanding Modes of Telehealth Delivery Practice and Additional Telehealth Providers Eligible for Payment or Reimbursement

STATE	STORE AND FORWARD	AUDIO-ONLY	TEXT/ EMAIL	OTHER	NON-PHYSICIAN	SPECIALIST	MENTAL/ BEHAVIORAL HEALTH (NON-PHYSICIAN)	THERAPISTS*	BROAD
AR							Yes		
CO	Yes(PI)	Yes(PI)	Yes(PI)	Yes(PI)					
CT	Yes(M)(PI)	Yes(M)(PI)				Yes	Yes	Yes	
DE	Yes	Yes							
GA									
HI		Yes			Yes		Yes		
ID									
IL	Yes(PI)	Yes(PI)		Yes(PI)	Yes(PI)	Yes(PI)	Yes(PI)	Yes(PI)	
IN	Yes(PI)	Yes(PI)						Yes	
IA		Yes(PI)							
LA		Yes(PI)					Yes(PI)		
MI	Yes(M)(PI)	Yes(M)(PI)							Yes(M) (PI)
MN									
MT	Yes(M)(PI)	Yes(M)(PI)	Yes(M)(PI)	Yes(M) (PI)					
NV									
NH	Yes(M)(PI)	Yes(M)(PI)	Yes(M)(PI)	Yes(M) (PI)	Yes	Yes	Yes(M)(PI)	Yes	Yes(M) (PI)
NJ				Yes					
NY					Yes		Yes		
ND		Yes(PI)							
OH	Yes(M)	Yes(M)	Yes(M)		Yes(M)	Yes(M)	Yes(M)	Yes(M)	
OK									
OR	Yes(M)	Yes(M)	Yes(M)	Yes(M)			Yes(M)		
PA									
TN					Yes	Yes	Yes	Yes(WC)	Yes
TX					Yes(PI)	Yes(PI)	Yes(PI)		Yes(PI)
VT	Yes(PI)	Yes(PI)	Yes(PI)			Yes(PI)			
WA									

* Includes physical, occupational, speech therapists, etc., but does not include mental or behavioral health therapists.

(M) - Indicates at least one provision relating to Medicaid

(PI) - Indicates at least one provision relating to private health insurance

(WC) - Indicates at least one provision relating to Workers' Compensation

Recommendations for Action

The physical distancing measures needed to limit COVID-19 spread also pose a substantial barrier to preventative services and general health care. Without such care, existing and emerging health conditions are likely to worsen, creating more harmful and expensive problems in the future (Sherrard-Smith et al., 2020; Stop TB Partnership, 2020). Telehealth must be fully leveraged to provide care while limiting opportunities for COVID-19 spread. Consequently, states should consider policy options to expand telehealth access and utilization even if those options allow less than ideal health care (e.g., telehealth over the phone). Some care is better than no care. Above all, governments should ensure that laws and the emergency modifications to those laws are clear to health care providers and the public.

Federal government:

To reap the benefits of telehealth during the COVID-19 pandemic and after:

- Congress should enact legislation:
  - Permitting Medicare and Medicaid reimbursement for patient training and education relating to telehealth digital literacy and encourage providers to target populations with known disparities in telehealth services.
  - Permanently extending the telehealth Medicare expansion permitting patients to receive telehealth from new locations, including rural health clinics, Federally Qualified Health Centers and patients' homes.
  - Permanently extending Medicare coverage of telehealth services that can be delivered to the same standard of care as comparable in-person services.
  - Permanently reducing or eliminating copayments and other out-of-pocket expenses for telehealth services that have demonstrated cost-savings compared to their in-person equivalent service.
  - Establishing mechanisms and funding for improving access to telehealth-capable devices for underserved and vulnerable populations.
- CMS should reduce or eliminate copayments and other out-of-pocket expenses for appropriate telehealth services during the COVID-19 response.
- HHS and CDC should monitor telehealth policy changes for inequitable outcomes, especially in vulnerable populations.

State governments:

To reap the benefits of telehealth during the COVID-19 pandemic and after:

- Legislatures should:
  - Lift restrictions on telehealth locations to permit both providers and patients to use telehealth from a safe location, including their homes.
  - Limit out-of-pocket expenses by restricting or reducing cost-sharing (e.g., co-pays, deductibles) for telehealth services.
  - Expand coverage of telehealth services provided by Medicaid and private health plans.
- Governors and state agencies should use their emergency powers during COVID-19 to
  - Permit new modes of telehealth, including asynchronous, store-and-forward, audio-only (e.g., telephone), and secure messaging/email.
  - Permit any health care provider to use telehealth for health care services if those services can be delivered to an acceptable level of care.
  - Permit out-of-state health professionals that are licensed and in good standing in their home states to practice telehealth within their jurisdiction.
- Governors and state agencies should vigorously implement telehealth parity laws to support health care providers with falling patient volumes during the COVID-19 response.

About the Authors

Cason Schmit, JD, is an assistant professor at the Texas A&M University School of Public Health, Department of Health Policy and Management. He actively researches how law impacts health information technology, including telehealth, health information exchanges, privacy, and confidentiality. Previously, he worked for the U.S. Centers for Disease Control and Prevention Public Health Law Program as a legal fellow and a contractor to promote law as a tool for public health and data sharing. He is a member of the State Bar of Arizona and earned his JD from the Sandra Day O'Connor College of Law at Arizona State University.

Johnathan Schwitzer is a J.D. candidate at Texas A&M University School of Law. He will sit for the Bar Exam in 2022. During his 1L summer, he interned for a United States District Court judge in the Northern District of Texas. He holds a B.S. in Political Science from Texas Wesleyan University.

Kevin Survance is a second-year law student at the Texas A&M University School of Law. Prior to attending law school, he received a bachelor's degree in Finance from the University of Oklahoma and an associate's degree in Business Administration from Redlands Community College.

Megan Barbre is a research assistant under assistant professor Cason Schmit at the Texas A&M University School of Public Health. She is a J.D. candidate at the Texas A&M University School of Law (2021) and received her B.A. in government from the University of Texas at Austin.

Yeka Nmadu is a second-year Master of Public Health student at the Texas A&M University School of Public Health, majoring in Epidemiology. As a research assistant, she studies how Texas and national telehealth law and policy impacts health care delivery. Her other interests include chronic disease and child health epidemiology. Previously, she worked as a general physician in Kaduna State, Nigeria, and was actively involved in the implementation of a focused clinic for diabetic patients. She earned her medical degree from the University of Ibadan in Nigeria.

Carly E. McCord, PhD, is a licensed psychologist and the Director of Telebehavioral Care at Texas A&M University. She is a Clinical Assistant Professor in the Departments of Psychiatry and Educational Psychology. She has a proven and documented expertise in providing high-quality mental health services via long-distance technology, engaging rural communities to reduce mental health disparities, and starting an innovative supervision model for telepsychology. In both research and practice she is well-versed in underserved populations, training and supervision, and telehealth.

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