SEPTEMBER 2021

TELEHEALTH EXPANSION DURING COVID-19

and the Future of Telehealth

PREPARED BY
The Arizona Hospital and Healthcare Association
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Summary</td>
<td>3</td>
</tr>
<tr>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>Telehealth Policy Changes in Arizona</td>
<td>6</td>
</tr>
<tr>
<td>Federal Telehealth Policy Changes</td>
<td>8</td>
</tr>
<tr>
<td>Benefits of Expanded Telehealth</td>
<td>9</td>
</tr>
<tr>
<td>Preventing the Spread of COVID-19</td>
<td>9</td>
</tr>
<tr>
<td>Increasing Access to Care in Underserved and Geographically Diverse Areas</td>
<td>10</td>
</tr>
<tr>
<td>Increasing Access to and Improving the Value of Behavioral Health Services</td>
<td>12</td>
</tr>
<tr>
<td>Increasing Access to Specialty Care</td>
<td>13</td>
</tr>
<tr>
<td>Challenges to Address and Risks to Mitigate with Telehealth Expansion</td>
<td>14</td>
</tr>
<tr>
<td>Physical Provider Network Adequacy</td>
<td>14</td>
</tr>
<tr>
<td>Quality of Out-of-State Provider Services</td>
<td>14</td>
</tr>
<tr>
<td>Best Practices for Determining High-Value Telemedicine</td>
<td>15</td>
</tr>
<tr>
<td>Technological Barriers &amp; Health Inequities</td>
<td>15</td>
</tr>
<tr>
<td>Challenges Specific to Behavioral Health</td>
<td>16</td>
</tr>
<tr>
<td>Overutilization and Increased Spending</td>
<td>17</td>
</tr>
<tr>
<td>Payment Parity</td>
<td>18</td>
</tr>
<tr>
<td>Conclusion</td>
<td>20</td>
</tr>
<tr>
<td>Telehealth Resources</td>
<td>21</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

Throughout the COVID-19 public health emergency, telehealth utilization has reached and sustained unprecedented levels, which can be largely attributed to state and federal policies that have allowed for widespread reimbursement of telehealth services. These policies have served to simultaneously promote patients’ access to care, provide revenue for providers when in-person care was not advisable and mitigate community spread of the virus.

Arizona Governor Doug Ducey temporarily expanded telehealth coverage in the state and required payment parity for health care services rendered via telehealth in issuing Executive Order 2020-15 at the onset of the pandemic on March 25, 2020. In the spring of 2021, the Arizona legislature passed and the Governor signed House Bill 2454, which essentially makes that Executive Order permanent and establishes Arizona as a nationwide leader in telehealth policy expansion.

On the national level, the U.S. Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) granted myriad flexibilities for the duration of the COVID-19 emergency enabling, among other things, federal dollars to be used to reimburse for telehealth services. Several bills have been introduced in Congress to codify various iterations of permanent telehealth expansion.

While there is general agreement that the COVID-19 telehealth expansion has yielded impressive benefits, including giving patients a lifeline to needed physical and mental health services during stay-at-home orders and quarantines, both state and national policymakers and stakeholders have expressed the need to monitor data and address challenges that may arise associated with the unprecedented telehealth expansion.

Within Arizona, specific concerns have related to the need to hold out-of-state telehealth providers accountable for the quality of care provided via telehealth to Arizonans. Some providers and other stakeholders are concerned about the lack of clear standards and best practices to guide providers regarding the best uses of telehealth versus in-patient encounters. H.B. 2454 contains provisions aimed at addressing both of these concerns, which will be closely followed by stakeholders. The Telehealth Advisory Committee established by H.B. 2454 will be closely watched as it develops telehealth best practice guidelines for Arizona providers.

At both the national and state levels, lawmakers and stakeholders express the need to address technological barriers in rural and underserved areas to create widespread access to telehealth services.
services. Some experts caution that permanent expansions of telehealth should be carefully tailored to ensure health inequities and disparities are addressed and not exacerbated. Other stakeholders warn that telehealth expansion may result in overutilization of care, while many studies have shown telehealth’s potential to decrease costs of delivering health care.

While payment parity for telehealth services has been codified in Arizona through H.B. 2454, it remains an area of debate, particularly at the national level. Some believe that rates should be reduced if telehealth services are less costly to provide, while advocates of a fair payment system believe providers should share in the cost-savings achieved by providing high-quality care through telehealth, similar to a value-based purchasing approach.

Telehealth’s benefits have been proven during the COVID-19 pandemic, and regardless of one’s perspectives on how to address the potential risks and challenges associated with expanded telehealth, this mode of care delivery will continue to shape Arizona’s and the nation’s health care delivery system well after the pandemic is over.
INTRODUCTION

Telehealth utilization has skyrocketed and maintained elevated levels throughout the public health emergency and across all provider and insurance types, solidifying telehealth as a vital component of the nation’s healthcare delivery system. Legislation passed by the Arizona Legislature and signed by Governor Doug Ducey in 2021, House Bill 2524, is considered the most expansive telehealth law in the country\(^1\) and has further propelled the advancement of telehealth in the state.

As an illustration of this unprecedented growth, immediately prior to the pandemic, 300 Mayo Clinic physicians and advanced practice providers had performed a video telemedicine consult within the preceding year; by July 15, 2020, the number of providers performing video telemedicine consults had grown to over 6,500, constituting a 2,000% increase.\(^2\) In the Medicare program, more than one in four beneficiaries accessed a telehealth service between the summer and fall of 2020.\(^3\) By comparison, only 0.1% of primary care visits in traditional Medicare were provided via telehealth before the pandemic in February 2020.\(^4\)

Throughout this great expansion, telehealth has yielded significant benefits to patients, providers and communities. For example, it has connected quarantined patients to needed physical and mental healthcare, it has protected providers from encounters with potentially COVID-19 positive patients, and it has mitigated community spread of the virus.

As compelling as these benefits are, telehealth does pose certain risks and challenges, which are discussed in detail in this paper from the viewpoints of various types of stakeholders. The

---

4. Id.
level of future telehealth expansion and the ultimate level of success of this health care delivery method will likely depend on the state’s and the nation’s ability to mitigate these risks and challenges.

TELEHEALTH POLICY CHANGES IN ARIZONA

On March 25, 2020, Arizona Governor Ducey signed Executive Order 2020-15, which allowed clinical evaluations to be conducted via telehealth and required payment parity for telehealth services for the duration of the pandemic. The policy aimed to encourage Arizona providers to make telehealth services available and help ensure that Arizonans had access to medical care during the emergency.

The Executive Order enabled a dramatic increase in telehealth utilization in Arizona. One healthcare facility found that while only a small minority of primary care providers had utilized telehealth before, 100% participation among primary care providers was achieved following the Executive Order. According to the facility, many providers previously had been reluctant to introduce a new method of care delivery that would require start-up time and temporarily impact workflow. But subsequent to the Executive Order, the providers were highly motivated to quickly learn how to incorporate telemedicine into their practice.

In the spring of 2021, the Arizona legislature passed and the Governor signed House Bill 2454 that essentially makes Executive Order 2020-15 permanent in addition to codifying other telehealth policy changes. The legislation was supported overwhelmingly by over three-quarters of the legislature, resulting in the bill becoming effective immediately.

H.B. 2454

- Requires health and disability insurers to cover telehealth services if the services would be covered in person
- Requires reimbursement for healthcare providers at the same level of payment for equivalent services that are provided in person
- Allows Arizonans to receive telemedicine services from out-of-state providers so long as the provider is in good standing with his or her state medical board and other conditions are met
- Permits prescriptions to be dispensed via telehealth
- Allows asynchronous and audio-only health encounters, removing the statutory requirement for real-time audio and video
- Establishes the 27-member Telehealth Advisory Committee on Telehealth Best Practices
Asynchronous telehealth, also called “store and forward,” occurs when services are not delivered in real-time but rather are uploaded by providers and retrieved. Audio-only refers to using a traditional telephone to conduct health care appointments and is permitted when the provider and patient have a pre-existing healthcare relationship and where access to audiovisual services is not reasonably available.

The Telehealth Advisory Committee on Telehealth Best Practices will review peer-reviewed literature and existing standards for telehealth best practices and will adopt best practice guidelines and recommendations for Arizona. The committee members represent a wide range of healthcare services and specialties and are appointed by the Governor. Once these telehealth best practices are determined by the committee, healthcare providers will be required to make a good faith effort to utilize them in determining whether a health care service should be provided through telehealth or in-person, and which medium of telehealth would be most appropriate.

HB 2454 constitutes an unprecedented expansion of telehealth in Arizona. Previously, the Arizona legislature had taken a piecemeal approach in adding services permitted by telehealth one by one. And previously, there was no requirement for payment parity for the same services permitted via telehealth as in-person. In fact, HB 2454 has been viewed as the most comprehensive telehealth expansion bills in the country.

Arizona’s legislative trailblazing in expanding telehealth services regardless of insurer type was preceded by the Arizona Health Care Cost Containment System’s (AHCCCS) policy modifications that expanded telehealth coverage within the state’s Medicaid program.

Specifically, in 2019, the AHCCCS Medical Policy Manual (AMPM) expanded coverage of synchronous (real-time) telemedicine services by eliminating the prior list of 17 medical specialties that were covered (e.g., cardiology, dermatology, endocrinology, etc.). Pursuant to the revised policy, AHCCCS covers all “medically necessary and cost-effective” synchronous telemedicine services without limitations on medical specialty. With respect to coverage of asynchronous (store-and-forward) telemedicine, the prior AHCCCS policy covered only certain medically necessary behavioral health and neurological services. The revised policy expanded asynchronous telehealth services to include six medical specialties, without geographic restrictions.

Arizona’s leadership in telemedicine is supported and enhanced by the Arizona Telemedicine Program, housed at the University of Arizona and operated under the direction of Dr. Ronald S. Weinstein. Among other things, the program oversees and coordinates telehealth-related clinical, educational, research and telecommunications programs across Arizona. The Arizona

---

State Legislature has also created the Arizona Telemedicine Council, which oversees the Arizona Telemedicine Program and the development of its telecommunications network.

**FEDERAL TELEHEALTH POLICY CHANGES**

Through Section 1135 waivers, CMS gave Medicare beneficiaries unprecedented access to telehealth services, enabling access to care without leaving their home and mitigating the spread of COVID-19.

The Centers for Medicare & Medicaid Services (CMS) utilized Social Security Act Section 1135 waiver authority to broaden access to Medicare telehealth services to enable beneficiaries to receive a wider range of services without having to travel to a healthcare facility and to prevent the spread of the virus.

Specifically, for the duration of the public health emergency, CMS allows Medicare to cover office, hospital and other telehealth visits provided by health care workers including physicians, nurse practitioners, clinical psychologists and licensed clinical social workers.8

Covered telehealth services include evaluation and management visits, preventive health screenings and mental health counseling. Additionally, these telehealth visits are reimbursed at the same rate as in-person visits during the pandemic.

Prior to CMS issuing these waivers, Medicare covered telehealth services only in very limited circumstances. The patient would have to be located in a designated rural area and was required to leave his or her home and travel to a clinic, hospital or certain other types of medical facilities to receive a telehealth service.

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act), which became law on March 27, 2020, authorized CMS to grant additional telehealth waivers. CMS has since waived federal requirements that limit the types of practitioners that may bill for telehealth services. Specifically, all health care professionals who are eligible to bill Medicare may be reimbursed for distant site telehealth services for the duration of the emergency. This includes physical therapists, occupational therapists, speech-language pathologists, among others.

Generally speaking, Medicare telehealth services must use audio and video equipment permitting two-way, real-time interactive communication between the patient and the provider. Pursuant to the additional waiver authority granted in the CARES Act, CMS permits audio-only telehealth for certain services, including evaluation and management services, behavioral health counseling and educational services, for the duration of the emergency.

Various members of Congress have introduced legislation to make COVID-19 telehealth flexibilities permanent. One bill, the Telehealth Modernization Act,9 introduced in both

---

7 Social Security Act § 1135
9 S.368, H.R. 1332
chambers of Congress by Senator Tim Scott and Representative Buddy Carter respectively, would codify many pandemic-era telehealth flexibilities. Specifically, the legislation would allow any health care professional who is eligible to bill Medicare to provide services via telehealth; expand “originating site” to include any site where the patient is located at the time the service, including their homes; allow HHS to retain the expanded list of telehealth services that were authorized during the public health emergency and direct HHS to consult with stakeholders regarding services that are clinically appropriate for telehealth.

The Protecting Access to Post-COVID-19 Telehealth Act of 2021, introduced by Representative Mike Thompson, would also make permanent various COVID-19 telehealth flexibilities. This legislation would allow federally qualified health centers and rural health clinics to serve as the distant site (i.e., the location of the healthcare practitioner) for telehealth services under Medicare. It would also permit Medicare beneficiaries to receive telehealth services from anywhere, including their homes. Furthermore, the bill would require Medicare payments to be equal to payments made for in-person services.

The CONNECT for Health Act of 2021, introduced by Senator Brian Schatz, similarly would expand access to telehealth services on a permanent basis and allow federally qualified health centers and rural health clinics to provide telehealth services. It would also provide the Secretary of HHS with the permanent authority to waive telehealth restrictions during public health emergencies, and it would require a study to gather more data on the impacts of telehealth.

PERSPECTIVES ON THE BENEFITS OF EXPANDED TELEHEALTH SERVICES

Preventing the Spread of COVID-19

Expanding telehealth for Medicare beneficiaries during the pandemic has been regarded as essential to enabling Americans who are most vulnerable to COVID-19 to receive medical care without exposing themselves to the virus. Similarly, telehealth reduces the spread of the virus to medical providers on the frontlines of the pandemic.

Protecting healthcare providers from exposure to the virus by utilizing telehealth in lieu of in-person encounters when possible yields another important benefit: mitigating provider shortages during the pandemic. Since exposed providers without adequate protection must quarantine for 14 days, provider shortages likely would have been significantly more severe without the use of acute telemedicine. Increased telehealth utilization has also benefitted

---

12 Id.
healthcare providers by generating some revenue for their practices while stay-at-home orders are in effect or when in-person visits are not feasible due to the patient or provider being quarantined.

Furthermore, the provision of acute telehealth services reduces community spread of COVID-19 by avoiding unnecessary hospitalizations. In a statement submitted to the U.S. House of Representatives Ways and Means Committee’s Subcommittee on Health (Ways and Means Health Subcommittee), the American Hospital Association (AHA) discussed the case of a hospital that set up a virtual facility with significant telehealth capabilities when the pandemic began. Nearly 18,000 patients were treated in the virtual hospital as of August 2020, with only three percent requiring transfer to a brick-and-mortar site. A significant number of hospitalizations were avoided, making the program exceptionally effective.

**Increasing Access to Care in Underserved and Geographically Diverse Areas**

Telehealth has been particularly useful for rural communities because of previously existing physician shortages, lack of high-speed broadband internet and telehealth’s ability to eliminate the barriers of time and expense to travel long distances.\(^\text{13}\) In one example of the gaps in care that telehealth can help to close, 70 percent of U.S. counties do not have access to a child psychologist.\(^\text{14}\)

In a statement submitted to the Ways and Means Health Subcommittee, the AHA highlighted how telehealth has created increased access to care for broad patient populations. The AHA explained that telecommunications technology increases patients’ access to physicians, therapists and other practitioners, which is especially important in areas of the country where recruiting and retaining providers is challenging and in areas where vulnerable populations often lack an entrance point to the health care system.


\(^\text{14}\) Id.
Many stakeholders agree that while telemedicine clearly benefits rural and wilderness areas immensely, it also benefits all geographic areas where patients are underserved or have challenges accessing healthcare, including inner-city urban areas. These patient populations can include minority populations, individuals who are uninsured or under-insured, those who lack a primary care physician or facility, those with limited transportation options, and individuals with multiple chronic conditions.

Dr. Jack Resneck, Jr., M.D., on the Board of Trustees of the American Medical Association, testified to the U.S. House of Representatives Energy and Commerce Committee’s Subcommittee on Health (Energy and Commerce Subcommittee) that telehealth provides access and convenience for patients living in inner cities who otherwise would have to miss work, spend time and money on transportation and face difficulties in obtaining child care. In Dr. Resneck’s experience, telehealth visits can also make patients more willing to share social determinants of health factors such as food insecurity.

Additionally, some experts assert that telehealth can help address racial disparities in health outcomes. A study by the Kaiser Family Foundation found that a greater share of Medicare beneficiaries with disabilities, with low incomes, and in communities of color have used telehealth during the pandemic.15 Other studies have shown that racial bias in doctors impacts maternity mortality and telehealth can make it easier for patients to find a doctor of the same race or speak the same language.16

16 Id.
Over the course of the COVID-19 public health emergency, telehealth utilization has increased the most for behavioral health services. This is partially due to a higher demand for behavioral health services during the pandemic. Experiencing the effects of isolation has contributed to depression, and telemedicine has given patients the opportunity to speak with a behavioral health professional at critical times.

An increased ability for patients to attend telehealth appointments may also contribute to higher behavioral health care utilization rates. An Arizona-based behavioral health care provider has witnessed an increase in patient attendance to levels of over 80 percent, compared with pre-pandemic levels of approximately 60 percent. This may be due attributed in part to negating the need for reliable transportation, which can be challenging for many underserved patient populations.

Other experts point out that the increase of behavioral telehealth services may also be partially due to mental health diagnoses and treatments being relatively well suited for telehealth as they are conducted through interviews instead of physical assessments.

There is wide agreement that the significant increase in behavioral healthcare services provided via telehealth has yielded crucial benefits, including contributing to suicide prevention efforts. The availability of receiving services through telehealth may reduce traditional barriers to seeking out mental health care including stigma. Additionally, the costs of telemedicine may be lower compared to traditional mental health care. Data gathered by Cigna has shown that behavioral health services rendered via telehealth increase patients’ productivity in the workforce and decrease sick days.

According to some national experts, behavioral healthcare services provided via telehealth contribute toward the movement toward value-based care. Thomas Kim, M.D., M.P.H., Chief Behavioral Health Officer at Prism Health North Texas, testified to Congress that telehealth facilitates preventive care instead of reactive care. In his experience, Dr. Kim has found that patients may wait until an issue is a crisis, which often leads to higher costs and poorer health outcomes. According to Dr. Kim, telehealth provides both an opportunity for patients to access

---

18 Id.
19 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7491639/
20 Id.
21 Id.
22 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7491639/
convenient preventive care that improves their health outcomes and an opportunity to lower healthcare costs.

**Increasing Access to Specialty Care**

Various small rural hospitals around the country use telehealth to give rural patients access to specialty healthcare services without having to travel long distances. Providing specialty care via telehealth is a far more feasible way than staffing the facilities with specialty and subspecialty providers to increase rural patients’ access to care. Telehealth services may be provided for virtually every specialty including behavioral health, primary care, dermatology, neurology and radiology.

One example of the impact of federal telehealth flexibilities issued during the pandemic on specialty care comes from an AHA hospital member that reported a 10-fold increase in access to specialists. The hospital reached 39 percent more ZIP codes in the state using telehealth, all while receiving very high patient satisfaction ratings. More efficient access to care for various clinical specialties has also been found to result in improved long-term clinical outcomes. For example, telemedicine can expedite the diagnosis and delivery of treatment during critical timeframes, such as immediately following a stroke or traumatic injury.

Several Arizona rural communities have benefitted from greatly increased access to specialty care through the U.S. Department of Agriculture’s Distance Learning and Telemedicine (DLT) grant program. The DLT program assists rural facilities with acquiring broadband, audio and visual equipment, data terminal equipment, computer hardware and software, and network components to enable rural facilities to connect with each other, other providers, patients, teachers and students to combat the effects of remoteness and low population density.

DLT program funding has enabled various rural facilities in Arizona to connect patients directly to urgently needed specialist care, which otherwise would be inaccessible in the patient’s geographic area. Not only does this increased access to specialty care benefit the patients, but it also assists rural primary care providers who are otherwise in the position of managing multiple conditions that may be outside their areas of expertise. Additionally, the technology enables both the patient and the primary care provider to consult with the specialist, which fosters care coordination and improves patient outcomes.

In some settings, telehealth may provide the option of accessing particular specialists who are not based in the same state as the patient. Megan R. Mahoney, M.D., Chief of Staff at Stanford Health Care, testified before Congress that California-based physicians are able to provide specialty care via telehealth to many patients outside of California when interstate restrictions

---

25 [https://www.ruralhealthinfo.org/topics/telehealth](https://www.ruralhealthinfo.org/topics/telehealth)
26 Id.
28 Id.
Dr. Mahoney stated that 30 to 40 percent of visits at Stanford Health Care that include every specialty are now conducted via telehealth.  

CHALLENGES TO ADDRESS AND RISKS TO MITIGATE WITH TELEHEALTH EXPANSION

Physical Provider Network Adequacy

During hearings at the Arizona legislature on H.B. 2454, some lawmakers expressed concerns that expanded telehealth could lead to an erosion of the physical network of health care providers. Methods to address this concern were incorporated into H.B. 2454, including prohibiting insurers from using contracted telehealth providers to meet network adequacy standards and providing that an insurer’s provider network is not considered adequate if enrollees are unable to access appropriate nonemergency in-person services from the plan’s provider network.

Even so, there are additional concerns about large, national or international telehealth companies whose providers do not establish in-person patient relationships but rather perform telehealth services exclusively. Some providers are concerned that scaled-back restrictions could provide an opening for large companies to increase their revenue at the expense of Arizona-based providers, thereby eroding the physical network of providers. It is also conceivable that patient outcomes could suffer if patients seek out telemedicine services from a large telehealth company that is covered by their insurance as a more convenient option than in-person care, but which may not be as effective a mode of treatment in the given circumstance.

Quality of Out-of-State Provider Services

Some Arizona legislators expressed concern about a proposal in H.B. 2454 to allow telehealth services to be provided to Arizona residents by out-of-state providers. These legislators expressed the need to ensure the quality of these services and the ability to hold these out-of-state providers accountable.

The final version of the legislation incorporates safeguards to address these concerns. An out-of-state provider who fails to comply with the applicable laws and rules of Arizona will be subject to investigation and disciplinary action, which may include revoking the provider’s practice privileges. The legislation also requires out-of-state providers to hold a current, valid, and unrestricted license to practice in another state; to register to practice telehealth in Arizona and pay a registration fee; to consent to Arizona’s jurisdiction for any legal proceeding related


30 Id.
to the provider’s actions; and to promptly notify the applicable board regarding any disciplinary action or restriction placed on the provider’s license by another state.

Additionally, H.B. 2454 requires data collection on the services provided by the out-of-state providers for ongoing monitoring and analysis. The out-of-state provider must report to the applicable Arizona state board each year the total number of Arizona residents served by the provider and the total number of encounters with Arizona residents during the preceding year.

**Best Practices for Determining High-Value Telemedicine**

H.B. 2454 established the Telehealth Advisory Committee on Telehealth Best Practices to adopt telehealth best practice guidelines and recommendations for use in Arizona. Many Arizona stakeholders welcome this strategy as they strongly support the need to put clear-cut best practices in place to guide providers in utilizing telehealth versus in-patient care depending on the specific circumstance and to establish expectations and uniformity with respect to a statewide pattern of practice.

Providers acknowledge that telehealth and in-person services each have their place depending on the patient and the situation. Telehealth is a tool that healthcare providers can use as a means for providing care for their patients if enabling technologies are available, but the appropriateness of that application must be taken into account. As the quality of care can vary for any service, telehealth included, best practices must also ensure that providers are continually held to high standards of care delivery including both value and efficiency. The establishment of clear standards for the use of telemedicine also decreases some stakeholders’ concerns that telehealth could become overutilized.

**Technological Barriers & Health Inequities**

A specific, ongoing challenge within Arizona and nationally is increasing access to care via telemedicine in rural areas to the same extent access to care is increased in other geographical areas. *Almost one-third of rural Americans do not have access to broadband internet at home.* Other barriers to care in rural and underserved areas include some patients’ lack of the technological knowledge to obtain virtual care, such as patients who are limited by flip phones or need assistance to access telehealth services, as well as a lack of technology and technological training for some rural providers.

In locations without high-speech connectivity or sufficient broadband and among populations without access to smartphones, requirements for telehealth visits to be real-time, audio-visual encounters greatly decrease utilization. For example, the majority of Medicare beneficiaries have reported accessing telehealth services by telephone only, causing concern for expanded telehealth benefits that require audio-visual communications. To address the concern of

---

31 [https://www.publicknowledge.org/issues/rural-broadband-access/](https://www.publicknowledge.org/issues/rural-broadband-access/)

---
disadvantaging certain populations within Arizona by requiring audio-visual encounters, H.B. 2454 permits asynchronous as well as audio-only telehealth if audio-visual is not reasonably available to the patient and if there is an existing relationship between the provider and the patient, with an exception for behavioral telehealth services.

Many stakeholders are concerned about the impact of varying access to telehealth services across the country. Ms. Hernandez Ocasio, Vice President for the Health Justice at National Partnership for Women and Families, cautioned Congress that the expansion of telehealth must not intensify long-standing health inequities. To prevent this, the digital divide must be bridged by reimbursing for audio-only visits, investing in nationwide, high-speed, reliable broadband, and bringing the required technology to patients. Additionally, telehealth must be affordable for providers, which may require an up-front investment by Congress to ensure that providers in all communities can offer telehealth services.

**Challenges Specific to Behavioral Health**

While the life-saving utility of behavioral healthcare services provided via telehealth during the pandemic and otherwise cannot be overstated, there are challenges specific to providing mental health care services through this application.

According to one Arizona-based behavioral health care provider, when a patient and provider are face-to-face, the patient is more likely to be up-front with information in starker terms about depression or another mental health condition. In person, the provider also has the benefit of viewing the entire person and being able to notice details such as bruising which could indicate domestic violence or elder abuse.

Within behavioral health, there are circumstances in which care provided via telehealth is considered to be appropriate and others in which it may be of lesser value. For example, some providers believe that telehealth visits are more effective if there is a pre-established provider-patient relationship and specifically an in-patient assessment that has already been completed. Telehealth may not be recommended if the patient may constitute a threat to themselves or others. And some providers have found that while certain types of illnesses such as affective orders (e.g. anxiety and depression) tend to be responsive to treatment via telehealth, other illnesses such as psychosis do not tend to be as responsive. Additionally, the provider’s affinity with using the technology or lack thereof can impact how comfortable the provider is with rendering services via telehealth, which can ultimately affect the quality of the services provided.

While many providers support the use of audio-only telehealth especially when audio-visual technology is not available, some have concerns about the advisability of providing audio-only behavioral health care services. These providers refer to the additional, vitally information available to the provider when viewing the patient including information gained from the patient’s body language.
Ateev Mehrotra, M.D., M.P.H., Associate Professor of Health Care Policy at Harvard Medical School, expressed his opinions to Congress that telemedicine can be too convenient for some, leading to more healthcare and increased healthcare spending. Similarly, Ms. Ellen Kelsay, President and CEO of the Business Group on Health, testified that a telehealth visit is sometimes followed by an in-person visit for the same purpose, resulting in doubling the cost for the same or very similar services. Ms. Kelsey testified that while telehealth shows promise in promoting cost-effectiveness in some ways, there is a need to be vigilant to ensure that telehealth does not increase costs over time.

A research paper in Health Affairs from April 2021 found telehealth can yield immediate savings by diverting healthcare from higher-cost settings, but there is a risk of negating the savings if the availability of telehealth leads to additional follow-up visits. The researchers evaluated direct-to-consumer telemedicine claims from a large commercial payer and found that 10.3% of these telemedicine visits led to subsequent in-person visits, compared to only 5.9% of in-person encounters.

On the other hand, there are indications that telemedicine may reduce healthcare costs over time. For patients with chronic conditions, telehealth can not only improve patient care and quality-of-life in the short term but may also lower overall patient and system healthcare costs in the longer term. In other contexts that require at least some in-person care, telehealth plays an important role in promoting efficiency. For example, in the case of a surgery, the provider may render pre- and post-surgery services such as patient education and self-management training via telemedicine.

Specifically, a study by the Veterans Health Administration demonstrated an average of $6,500 in annual savings for each patient that participates in its telehealth program, which translates to nearly $1 billion in savings in one year. Additionally, a study conducted by the California Public Employees Retirement System found that patients were less likely to require a follow-up visit after a telehealth visit. Only 6% of telehealth visits resulted in a follow-up visit whereas 13% of office visits and 20% of emergency department visits for similar conditions required follow-up visits.

---

34 Id.
36 Id.
Some stakeholders point out that telehealth can lead to overutilization and increased healthcare costs due to fraud. Several large fraudulent schemes have been recently discovered in which telehealth companies bill Medicare and other insurers for telehealth services that never occurred. But experts point out there is significant fraud in the Medicare system generally, and it is not specific to telehealth. For example, Dr. Mehrotra testified that $1.2 billion in taxpayer dollars have been lost to durable medical equipment (DME) fraud. To safeguard Medicare from fraud in telehealth, the Medicare Payment Advisory Commission (MedPAC) has recommended that an in-person visit should be required before before high-cost DME or clinical lab tests may be ordered. MedPAC and other experts have also recommended that outlier clinicians who deliver significantly more telehealth services than average should be carefully scrutinized.

Despite—or perhaps due to—the differing predictions about the long-term cost-effectiveness of telemedicine, there is one thing that experts tend to agree on: telehealth utilization data should be collected and analyzed to monitor cost-effectiveness over time. The myriad uses for telehealth data include ensuring that

- those who are vulnerable due to lack of access to providers, the burdens of managing serious health conditions or otherwise, are receiving quality care;
- those who lack access to the internet, technological hardware or digital literacy are able to use telehealth;
- quality of telehealth services is consistent across communities, populations and geographic areas, segregating data by geographic area, race, ethnicity and other data points; and
- health outcomes and cost-effectiveness of telehealth are compared with those of in-person care.

**Payment Parity**

H.B. 2454 requires insurers to reimburse healthcare providers at the same level of payment for equivalent services whether the services are provided in-person or via telehealth. Many Arizona stakeholders agree with this policy. Supporters of payment parity maintain that varying the application of service (in-person vs. telehealth) does not and should not change the quality of care that is expected and required and, therefore, payment rates should be identical. If a lesser service is all that can be provided via telehealth, then the service should not be provided via telehealth at all. Moreover, services that are provided to patients via telehealth require the same preparation, effort and medical decision-making by the provider.

---

37 Id.
There are dissenters to payment parity, those who believe costs of providing telemedicine will be lower than costs of providing in-person care and payments should reflect those lower costs. Stakeholders including the AHA point out there are substantial upfront and ongoing costs of establishing and maintaining the virtual infrastructure, including secure platforms, licenses, information technology support, scheduling, patient education and clinician training.

Moreover, some stakeholders point out that if providers are able to provide more cost-efficient care by increasing the proportion of telehealth services, then from a value-based purchasing perspective, the providers should share in those cost-savings. The fair payment perspective contemplates that data will show that expanded telemedicine yields superior health outcomes as well as significant cost savings, and it follows that private insurance companies in particular should reimburse at higher rates for telemedicine services. Additionally, if telemedicine visits require more resources and training than in-person care to comply with best practices, telemedicine payments should be adjusted upward accordingly.

Fair payment also contemplates that lines of care that only exist in the telemedicine application should be reimbursed under a separate reimbursement methodology that is not tied to in-person care rates. For example, telestroke, which is a rapid virtual examination of a suspected stroke patient, is a distinct service available only through telemedicine and should be reimbursed at a rate that is equitable considering its value and cost-effectiveness.

---

CONCLUSION

Throughout the COVID-19 pandemic, telemedicine’s great benefits to patients, providers and public health have been on display. Telehealth has succeeded at serving as a lifeline to healthcare for patients quarantined at home, protecting providers from exposure during in-person encounters and increasing access to both routine and specialty care. While expanded telehealth is likely here to say, especially within Arizona, potential risks will continue to be discussed and addressed.

On the state level, attention will be on the Telehealth Advisory Committee on Telehealth Best Practices as it develops telehealth best practice guidelines and recommendations, which Arizona providers will be required to utilize in determining whether a healthcare service should be provided through telehealth or in-person. Stakeholders will also want to watch for data and other information that is released showing telehealth utilization trends including across specialties and insurance types, in-state versus out-of-state providers, and outcomes compared with in-person care. The extent to which out-of-state telehealth providers are being held accountable for the quality of care provided via telehealth to Arizona patients will also need to be monitored.

On the state and national levels, stakeholders are expected to continue urging governments to address technological barriers in rural and underserved areas in various ways, including nationwide broadband, to equate access to telehealth services across the country. Proponents of health equity will want to ensure that the expansion of telehealth does not exacerbate already existing inequities concerning access to care and quality of care. Other stakeholders will watch the data closely to determine trends in short- and long-term cost-effectiveness and quality of care. Last but not least, payment parity is expected to be a hot topic federally where it remains an issue of contention, and possibly on the state level as the effects of H.B. 2454 unfold.
1. The Arizona Telemedicine Program housed at the University of Arizona provides a wealth of resources about telemedicine, including educational events, a blog, a telehealth service provider directory, and information about the Arizona Telehealth Council, which has oversight over the Arizona Telemedicine Program.

2. The Arizona Health Care Cost Containment System website provides information about the telehealth services it covers as well as telehealth flexibilities adopted during the public health emergency.

3. This Centers for Medicare and Medicaid Services webpage explains the Social Security Act Section 1135 waiver authority that allowed it to issue a multitude of telehealth flexibilities for the duration of the public health emergency and outlines the applicable flexibilities.


6. This American Hospital Association statement explains the AHA’s views on telemedicine and was included in the record of the U.S. House of Representatives Ways and Means Subcommittee on Health’s April 28, 2021 hearing.

7. The U.S. Department of Agriculture’s website provides information about its Distance Learning and Telemedicine grant program, which has led to significant increases in access to specialty care for rural communities.

8. The Rural Health Information Hub’s Rural Telehealth Toolkit provides extensive information about telemedicine in rural communities, gives guidance to rural facilities in implementing a telehealth program, and provides a wealth of links to other telehealth resources.
9. The Center for Connected Health Policy, a nonprofit organization with the mission of advancing telehealth nationwide, releases telehealth reports, sends newsletters, offers webinars, and provides many other telehealth resources.

10. The Kaiser Family Foundation’s Telehealth in Medicare Issue Brief offers myriad statistics on Medicare beneficiaries’ use of telemedicine during the pandemic and outlines issues to consider concerning expanded telehealth post-pandemic.

11. A Mathematica Report submitted to the Medicaid Payment Advisory Commission analyzes changes in Medicaid telehealth policies due to the pandemic.

12. The Medicaid Payment Advisory Commission included analysis and recommendations regarding telehealth expansion within its March 2021 Report to the Congress.