Leadership Council of Aging Organizations

Draft LCAO Telehealth Principles – May 5, 2021

As technology expands and service delivery becomes increasingly complex, all of us should have consistent access to health care and long-term services and supports (LTSS), including home and community-based services (HCBS). Telehealth services have expanded exponentially during the 2019 Novel Coronavirus (COVID-19) public health emergency (PHE), and consumer use of telehealth has reached record high numbers across different insurance types, providing a lifeline for many during the pandemic.[1] Among older adults and people with disabilities in particular, access to mental health services, nursing facility services, and HCBS through telehealth has proved essential. It has allowed them to address their rising mental health needs, reduce isolation, receive case management assistance and adult day services, and more while protecting them from COVID-19.

In the wake of such rapid growth, many federal and state policymakers are considering permanent implementation of expanded telehealth services beyond the pandemic. Policies being considered often mirror efforts by the U.S. Department of Health and Human Services (HHS), the Centers for Medicare & Medicaid Services (CMS), other federal agencies, and Congress to increase access to a wide range of telehealth services during COVID-19.

As demonstrated during the COVID-19 PHE, telehealth can improve access to health care services for millions of older adults and individuals with disabilities, especially for people who are unable to leave their homes, lack transportation, or have other barriers to access, whether they reside in rural areas or in city centers. For the Medicare population, availability of audio-only telehealth services has greatly increased access. However, sizable groups of older adults and individuals with disabilities lack the opportunity or capability to participate in two-way audio-video telehealth visits. Barriers to telehealth access, especially two-way audio-video, include insufficient broadband coverage, unaffordability of "smart" devices and internet services, discomfort with telehealth, lack of digital and technology literacy, challenges from cognitive impairment, and physical abilities that make reliance on video-enabled devices problematic.[2,3] Although much research regarding telehealth and disparities is needed, one study has already found telehealth disparities associated with older age, race, ethnicity, preferred language other than English, and low-income.[4]

We generally support the permanent expansion of telehealth services if careful and thoughtful consideration is given to critical issues such as facilitating consumer access and preventing exacerbation of health disparities. Central to such consideration is the clinical appropriateness of any service provided via telehealth—including services provided via audio-only modalities, without

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[1] Koonin, L., Hoots, B., Tsang, C., et al. (2020). Trends in the use of telehealth during the emergence of the COVID-19 pandemic — United States, January–March 2020. *MMWR Morb Mortal Wkly Rep 2020*, 69(42), 1595–1599. http://dx.doi.org/10.15585/mmwr.mm6943a3

[2] Amin, K., Rae, M., Ramirez, G., & Cox, C. (2020). *How might internet connectivity affect health care access?* [Web log post]. https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access

[3] Kakulla, B. (2020). *2020 tech trends of the 50+*. AARP Research. https://doi.org/10.26419/res.00329.001

[4] Eberly, L. A., Kallan, M. J., Julien, H. M., et al. (2020). Patient characteristics associated with telemedicine access for primary and specialty ambulatory care during the COVID-19 pandemic. *JAMA Network Open*, 3(12), e2031640. doi:10.1001/jamanetworkopen.2020.31640

originating site or geographic restrictions, without a preexisting consumer–provider relationship, and with suitable reimbursement. Any advancements in telehealth should be implemented in a way that maintains consumer privacy and protections, is paired with the collection and analysis of robust data, does not exacerbate disparities or restrict access to in-person services or clinicians, or evade best practices with respect to staffing.

The Leadership Council of Aging Organizations (LCAO) is a coalition of national nonprofit organizations concerned with the well-being of America's older population and committed to representing their interests in the policy-making arena. These principles are grounded in the experiences and needs of the older adults we represent. Applying these principles to the Medicare and Medicaid programs serving older adults is our primary, but not exclusive, goal. At the same time, we believe the principles have applicability to all consumers of health care services. LCAO offers the core principles outlined in this document to inform policy deliberations on telehealth. Moreover, the coalition supports funding, policies, and programs to realize these principles. By working together, we can put in place all the pieces of the telehealth access puzzle.

Defining Telehealth

As diverse sectors, payers, and partners enter the space of health service delivery via telecommunications technologies, it becomes increasingly important that the terminology and definitions used to describe "telehealth" are broad enough to include the continuum of services provided. In particular, we find the following definition of *telehealth* employed by CMS unclear, narrow in scope, and outdated: "the exchange of medical information from one site to another through electronic communication to improve a patient's health."[5] Additionally, CMS has separate definitions for telehealth-related services under Medicare and Medicaid, and confusing definitions for different services such as Medicare telehealth visits, virtual check-ins, and e-visits.[6,7] CMS often uses terms such as "telehealth" and "telemedicine" interchangeably, resulting in further misunderstanding—and, sometimes, unexpected costs—among providers and beneficiaries.

In contrast, the Health Resources & Services Administration (HRSA) defines telehealth as "the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration."[8] Assuming a broad definition of "clinical" that incorporates all professional services, this HRSA definition better incorporates the vast array of telehealth offerings available to older adults and individuals with disabilities, such as HCBS and evidence-based disease prevention and management, as well as the different modalities of delivering telehealth care. LCAO recommends that Congress and CMS update the definition of "telehealth" to be more inclusive of the services

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[5] Centers for Medicare & Medicaid Services. (2020). *Medicare telemedicine health care provider fact sheet.* https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[6] Centers for Medicare & Medicaid Services. (2020). *Medicare telemedicine health care provider fact sheet.* https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

[7] Centers for Medicare & Medicaid Services. (n.d.). *Telemedicine.* https://www.medicaid.gov/medicaid/benefits/telemedicine/index.html

[8] Health Resources & Services Administration. (2020). *Telehealth programs.* https://www.hrsa.gov/rural-health/telehealth

provided by the aging and disability networks. We also recommend that, following these updates, HHS mandate that one definition be used consistently across Medicare, Medicaid, and other payers.

Core Telehealth Principles

1. **Prevent exacerbation of disparities** – Because of disparities in access to broadband, technology, digital literacy training, and abilities, telehealth expansion will not benefit all older adults and individuals with disabilities equally or equitably. Such disparities can be caused by racism (both interpersonal and systemic), classism, insufficient resources, and lack of attention. Other factors influencing telehealth accessibility for older adults and people with disabilities—many of which disproportionately affect communities of color—include economic security, geography, insurance coverage, literacy (digital, financial, health, and reading), preferred language, and the cultural responsiveness of telehealth policies and programs. Consequently, the following accommodations and policies should be included in telehealth expansion to ensure equitable access:
    - Strengthen, modernize, and enforce existing civil rights laws and regulations, including those governing the right to interpreters and provision of materials in languages other than English and in alternative formats. Telehealth modalities should also be compatible with screen reading software and other assistive technology, consistent with the latest version of Web Content Accessibility Guidelines. Consumers should be informed about their rights related to telehealth and how to file a complaint.
    - Require all payers to cover multiple access modalities, including audio-only and other non-broadband-based modalities, which are critical to many older adults and individuals with disabilities—especially for people with low incomes—who cannot access or use two-way audio–video devices.
    - Develop culturally responsive policies and meaningfully address lack of or limited access to reliable broadband, technologies, and digital literacy training.
    - Ensure any expansion of telehealth coverage under Medicare Advantage is equally available in traditional Medicare.
    - Mandate collection and analysis of demographic data, as described in point six, related to access to telehealth services.
2. **Ensure telehealth services complement, not supplant, in-person care** – After the PHE, access to in-person care should not be impacted by the growth of telehealth and access to telehealth should be based on each individual beneficiary's own preferences and needs throughout the delivery of services. To prevent such supplantation, plans should not be allowed to count telehealth toward network adequacy standards. Furthermore, providers and plans should not discriminate against any older adult or person with disability who is unable or unwilling to receive services via telehealth.
3. **Ensure that covered telehealth services are clinically appropriate** – Telehealth services should be clinically appropriate, that is, congruent with each consumer's condition, choices, and needs, and assessed for their quality as well. To realize this goal, federal policies are necessary to facilitate meaningful review and research, with broad stakeholder input, of clinical appropriateness and quality for various sectors, providers, services, and consumers.
4. **Develop and enforce telehealth consumer privacy and protections** – Many privacy requirements, such as portions of the Health Insurance Portability and Accountability Act,

have been waived during the COVID-19 PHE. After the PHE, these requirements should return to their enforceable status. Providers should also be required to give notice, in plain language, before and after any service is delivered via telehealth and obtain consent from the individual. Such notice should include information on any applicable cost sharing, no-show fees, and other frequently asked questions (such as how to address lack of reliable internet, the right to interpretation services and reasonable accommodations and how to obtain them, cost if a telehealth visit ends early, and cancellation). As telehealth evolves, consumer privacy protections should be strengthened to keep pace.

5. **Allow providers to deliver and consumers to receive services at any site by removing originating and geographic site restrictions** – All consumers should have access to telehealth services regardless of their originating site or the location of the provider, and Medicare and Medicaid should cover. Additionally, policymakers should look for ways to verify the validity of the consumer–provider relationship when appropriate and to maintain other consumer protections without imposing additional barriers to care.
6. **Ensure appropriate reimbursement for telehealth** – To ensure provider participation and consumer access to telehealth, reimbursement rates for telehealth services should be sustainable and reflect providers' telehealth investments and ongoing expenses to maintain it, adequate to ensure that consumers have ongoing access to robust and equitable telehealth services, and established so as not to incentivize providers to steer consumers toward either route. Reimbursement for telehealth services should account for the relative values of the service, work, and resources needed to deliver care, as well as efficiencies, just as in-person care is calculated.
7. **Require the collection and analysis of telehealth data** – As telehealth becomes more common, there should be public release of data from all payers (such as Medicare, Medicaid, and private payers), including the type of services provided, consumer experiences and preferences, programmatic and consumer spending, health outcomes, and quality measurements. This should include detailed demographic data by the following categories: race, ethnicity, age, disability status, preferred language, sex, sexual orientation, gender identity, socioeconomic status, insurance coverage, and geographic location. Data collection and analysis should be consistent with patient privacy laws, including an opt-out process for consumers who do not wish to provide demographic data and clear deidentification procedures for protected health information. Each federal department or agency involved in such data collection and analysis should independently report to the public on its monitoring, oversight, and evaluation of telehealth data.

LCAO is ready to collaborate with Congress and the Administration to apply these telehealth principles to equitable, sound, and safe policy solutions that will help us all. Please visit www.lcao.org for additional information.

Adopted in XX 2021