VIRTUAL WORKSHOP SUMMARY

Policy-Informed Telehealth Research

The Minnesota Department of Health (MDH) hosted a virtual workshop on policy-informed telehealth research on February 27, 2023. The workshop brought together leading researchers and experts to discuss best practices and recommendations to study the impact of telehealth on health care access, quality, health outcomes, costs, and health equity. Discussions attempted to identify what types of data and study designs would produce timely and relevant information to shape telehealth policy decisions, while addressing approaches to methodological challenges.

OVERVIEW OF MINNESOTA'S TELEHEALTH STUDY

Presented by Pamela Mink, PhD, MPH
Director of Health Services Research, Health Economics Program, Minnesota Department of Health

Minnesota Telemedicine Act of 2015

The Minnesota Telemedicine Act was enacted into law in 2015. Under this legislation, commercial payers and Minnesota Health Care Programs, including Minnesota Medical Assistance (Medicaid) and Minnesota Care (Minnesota's basic health plan), were required to reimburse telehealth visits at parity with in-person visits. Audio-only visits were not subject to these parity laws.

The Minnesota Telemedicine Act included some rules and guidelines for Minnesota Health Care Programs about what types of clinicians can provide telehealth services and where patients can receive these services. Individuals receiving telehealth services also had to be established patients with at least 1 in-person

visit as a prerequisite to engaging in telehealth visits.

For commercial payers, the Minnesota Telemedicine Act covered synchronous and store-and-forward telehealth services, but not remote patient monitoring. There were no originating site restrictions for commercial payers, and patients could not be charged a greater deductible or copay for telehealth visits than with in-person visits.

Minnesota Telehealth Act of 2021

The COVID-19 pandemic necessitated many telehealth flexibilities at the state and federal levels to maintain access to care as in-person care became more challenging. Telehealth flexibilities included removing originating site restrictions, increasing out-of-state licensing, allowing audio-only coverage, expanding coverage to additional specialties, and allowing clinicians to treat new patients using telehealth. The Minnesota Telehealth Act of 2021 codified many of these telehealth flexibilities. However, the extension of payment parity to include audio-only visits is scheduled to sunset in June 2024 and will need to be revisited to decide whether it should be continued.

Minnesota Study of Telehealth Expansion and Payment Parity

The Minnesota Telehealth Act of 2021 directed the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS) to study the impact of these policies on health care delivery for Minnesotans covered by commercial plans (led by MDH) and Minnesota Health Care Programs (led by DHS).

Study Questions

As directed by the Minnesota Legislature in the Telehealth Act of 2021, the MDH-led telehealth study will evaluate the impact of telehealth expansion and payment parity on:

- Access to health care services, quality of care, health outcomes, patient satisfaction, value-based payments, and innovation in health care delivery

- Health care disparities and equitable access for underserved communities

- Health care costs and premiums

- Access to and availability of in-person care (including specialty care), particularly in rural areas

The study will also address:

- The extent to which telehealth services substitute for, or are in addition to, in-person services

- How increased access to telehealth positively or negatively affects health outcomes for certain services or populations

- Whether audio-only telehealth supports equitable access to health care services (including behavioral health services)

- Whether telehealth visits eliminate barriers to care for underserved populations without reducing the quality of care, worsening health outcomes, or decreasing patient satisfaction

- How payers ensure telehealth services are appropriate to patient needs and remain optional

Study Approach

As part of this study, MDH is learning from other states that have conducted similar studies. MDH is also engaging with the research community to examine the literature on telehealth, including a focused review on audio-only telehealth by the Center for Evidence-based Policy at Oregon Health & Science University. In addition, MDH is examining the telehealth landscape in Minnesota to identify who uses telehealth services, who provides telehealth services, what defines these services, and how that has changed over time.

Wilder Research was engaged to interview patients, clinicians, and payers in Minnesota about qualitative aspects of telehealth services. MDH may conduct additional surveys or key informant interviews in 2023.

MDH will pursue quantitative analyses using the Minnesota All Payer Claims Database (MN APCD) and electronic health record (EHR) data. The MDH Technical Advisory Group (TAG) was formed to share insights on all aspects of the telehealth study and will continue to engage stakeholders throughout the study.

Preliminary Qualitative Results

The results from Wilder Research found patients, clinicians, and payers perceived an increase in access to care as a result of the availability of telehealth services during the COVID-19 pandemic. Study participants generally agreed on several benefits of telehealth, including increased flexibility for scheduling appointments, reduced wait times, easing of transportation and child care challenges, and reduced risks associated with receiving care in-person, especially during the early stages of the COVID-19 pandemic. Clinicians felt telehealth visits were well-suited to several types of routine care, including chronic illness management, medication management, mental health care, and follow-up care.

Perspectives on payment for telehealth visits varied. Patients generally felt telehealth should be available as an affordable option for care. Clinicians felt reimbursement should be based on the service and expertise of the clinician, and be similar for telehealth and in-person care. Payers expressed interest in more flexibility in reimbursement rather than mandated parity, and a desire to find and set mutually agreeable reimbursement rates with clinicians.

Preliminary Quantitative Results

The preliminary quantitative results, informed by analyses of the MN APCD and MDH surveys, have been consistent with findings on a national level and in other states. Telehealth use in Minnesota increased dramatically in 2020 and has leveled off to some degree, while still being much higher than pre-2020 levels. A high percentage of behavioral health services were still being delivered by telehealth in mid-2021. Overall, patient satisfaction is high for telehealth, and satisfaction is similar for audio-only and audio-video telehealth services. Minnesotans who are Black, Indigenous, and People of Color (BIPOC) are somewhat less satisfied with telehealth services compared with White Minnesotans.

What's Next

Many important research questions remain and will be MDH's focus for the remaining portions of the study. Some considerations are:

- What services should be allowed for audio-only telehealth? What should the coverage and reimbursement of those services look like?

- How does telehealth affect equity, access, quality, and health outcomes?

- How does telehealth expansion affect the availability of in-person care and patient choices?

- Does telehealth work well or poorly for certain types of visits or services?

- Is telehealth beneficial for certain patients based on factors such as health conditions or demographic characteristics?

- How does telehealth affect health care spending?

The final report for the Minnesota Study of Telehealth and Payment Parity is due to the legislature in January 2024 and will be made public on MDH's website for the Minnesota Study of Telehealth Expansion and Payment Parity.

POLICY OVERVIEW: HOW CAN TELEHEALTH RESEARCH BEST INFORM POLICY DECISIONS?

Presented by Julia Harris, MIA, MPH
Associate Director, Bipartisan Policy Center

COVID-related Medicare Policy Changes

Significant changes were made to state and federal telehealth policy at the beginning of the COVID-19 pandemic, such as waiving geographic and site limitations for Medicare beneficiaries. Before the COVID-19 pandemic, Medicare beneficiaries had to travel to designated sites to receive telehealth services. When these limitations were lifted, beneficiaries could access virtual services from their home.

Pandemic-related policy changes also allowed Medicare to reimburse for audio-only services (not previously reimbursable) at parity with in-person services. This was intended to minimize barriers to telehealth services due to not having access to broadband or having limited digital literacy. Additional Medicare services became eligible for telehealth and requirements were relaxed around cross-state licensing.

Medicare Data Analysis

The Bipartisan Policy Center analyzed Medicare fee-for-service data to examine trends in telehealth use from pre-COVID through the

third quarter of 2021. This analysis found very little telehealth usage among Medicare beneficiaries before the pandemic, due in large part to policy restrictions on the benefit. There was a substantial increase in overall telehealth use as those policy restrictions were lifted early in the COVID-19 pandemic. Telehealth use began to decline and level off in late 2020 and early 2021, but remains much higher than before the pandemic. Specifically, telehealth usage in 2021 remained almost 40 times higher than prepandemic levels.

Primary care visits made up the largest share of telehealth visits covered by Medicare during the pandemic, 95% of which occurred within established patient-clinician relationships. Telehealth also became a major part of the behavioral health care delivery system; 44% of all behavioral health visits for Medicare beneficiaries were by telehealth by the end of 2021. This trend will only sustain itself if the policy environment continues to support it.

Unlike primary care, about 65% of behavioral health visits using telehealth were delivered outside of established patient-clinician relationships. In 2021, about 1 in 5 telehealth visits for behavioral health in Medicare were delivered using audio-only telehealth. This modality extends an important lifeline for older adults and rural populations who are disproportionately affected by barriers to accessing services. However, further research is needed on the impact of audio-only telehealth on quality of care and health care spending.

Similar to findings across other payers, after lifting geographic restrictions, rates for

Medicare telehealth visits directly correlated with population density, with telehealth use being much higher in urban areas compared with rural areas. Medicare beneficiaries eligible due to a disability and those with multiple chronic conditions are more likely to use telehealth services compared with other Medicare beneficiaries. In contrast to findings across many other payers, racial and ethnic minority beneficiary populations in Medicare used telehealth at a higher rate compared with non-Hispanic White beneficiaries.

Federal Telehealth Policy Landscape

At the end of 2022, Congress extended the Medicare telehealth flexibilities until December 31, 2024, with additional support for behavioral health crisis services and the 988 Lifeline program. Medicare coverage of telehealth services was also extended for marriage and family therapists and licensed mental health counselors, some barriers for substance use treatment were removed (including the requirement to obtain a waiver to prescribe buprenorphine), and 200 new residency slots for psychiatry and psychiatry subspecialties added.

In the aftermath of telehealth flexibilities during the COVID-19 pandemic, policymakers are in the process of critically examining which flexibilities should be made permanent and which should be rolled back. Currently, telehealth visits (including audio-only and audio-video) continue to be reimbursed at parity with in-person visits under Medicare. It will be important to see whether these policies

change when the 2024 Medicare Physician Fee Schedule is released at the end of 2023.

In February 2023, the Drug Enforcement Administration released proposed rules on substance use disorder treatment and controlled substance prescribing after the COVID-19 public health emergency ends. These proposed rules include new in-person visit requirements for certain prescriptions, which may result in patients losing access to needed medications.

POLICY-INFORMED TELEHEALTH RESEARCH PANEL

Presented by:

- *Ateev Mehrotra, MD, MPH*
  Professor, Department of Health Care Policy, Harvard Medical School

- *Annette Totten, PhD, MPA*
  Associate Professor, Oregon Health & Science University

- *Jiani Yu, PhD*
  Assistant Professor, Weill Cornell Medicine's Division of Health Economics and Policy

Moderated by Jean Abraham, PhD
Professor and Head, Division of Health Policy and Management, University of Minnesota

Telehealth Research Challenges

Despite the large quantity, much of the existent telehealth research is of low to moderate quality, without much strong evidence applicable to decision makers. This seems particularly true for claims about the evidence on models of private telehealth-only companies

simply because research on those models have been published in a journal, regardless of academic or professional quality.

Among the challenges faced by telehealth researchers are:

- **Determining the intended goal of using telehealth.** It is often not clear if the goal of telehealth was to increase access to care, replace or supplement in-person services, provide data, reduce costs, or better distribute scarce resources. Once there is a clear understanding of the goals, it is easier to conceptualize the best research questions, comparators, and outcomes to study.

- **Defining the scope of telehealth.** Telehealth can be anything from a phone call to remote surgery. The scope of telehealth is too broad for questions about what the effect of telehealth is, or whether telehealth "works" to be broadly useful or applicable. The answers to these questions depend on several factors, including the patient population, clinical circumstances, and modality of telehealth.

- **Applicability of telehealth research.** Researchers must decide which results from 1 condition or population can be translated to another, since researchers cannot feasibly study all aspects and applications of telehealth. There is some telehealth research on very specific topics, making it difficult to determine where additional evidence is needed and where generalizations can be made.

- **High propensity for selection bias.** Study designs that do not address selection bias may lead to incorrect inferences about telehealth. Selection bias stems from both

patients and clinicians using telehealth. For instance, individuals who use telehealth services are likely to be younger, healthier, and live in more urban areas than their counterparts. Most of the policy debate around access to telehealth is on the digital divide and whether patients have access to the necessary tools to have a video visit. However, research suggests the decision to use audio-only telehealth is actually driven by clinicians. Many clinicians who treat patients from disadvantaged populations are less likely to have the capacity to conduct video visits, or may be biased in which patients they select for video visits.

- **Identifying counterfactuals.** Counterfactuals allow researchers to compare individuals who use telehealth with those who do not. Most individuals started using telehealth during the COVID-19 pandemic, making it difficult to identify counterfactuals (i.e., the people who are not using telehealth) to estimate the impact of telehealth.

Study Designs

Causal Study Designs

Causal study designs such as randomized controlled trials (RCTs) are ideal for telehealth research. In one application of this study design, patients are randomized to a telehealth visit. Randomization ideally leads potential confounders to be evenly distributed in the treatment and control groups. Therefore, any associations between telehealth visits and patient outcomes can be attributed to telehealth itself and not other confounding factors.

Natural Experiments

Many of the barriers preventing the uptake of telehealth were eliminated during the COVID-19 pandemic, which presented an opportunity to learn how these policy changes affect various outcomes. In cases when RCTs are not practical or ethical, researchers may leverage existing variation in telehealth exposure, which subjects individuals to as-if randomization. This is referred to as a natural experiment.

Differences in insurance policies have been commonly leveraged in telehealth research as a source of natural variation. For example, researchers can compare patient outcomes among individuals enrolled in Medicare Advantage plans with those enrolled in Medicare fee-for-service, because they were

Limitations of Randomized Controlled Trials

There are several limitations to causal study designs:

- May be subject to selection bias
- Randomization may not be practical
- Can be costly and time-intensive
- Randomization may not be ethical in every situation
- May suffer from limited external validity, meaning the study findings may not be generalizable to a broader population or to different contexts outside of the experiment

subject to different telehealth benefits that changed over time.

Researchers can also leverage variation in telehealth policies across states. When examining state variation in telehealth policies, it is important to consider the trends in telehealth use in those states before any policy changes. For instance, if the trajectory of telehealth use differed prior to the change in telehealth policy between 2 states, this may suggest factors other than the policy change itself are contributing to the change in telehealth use.

Difference-in-differences frameworks, while having some limitations, are a type of natural experiment used to overcome issues with selection bias and identification of a counterfactual. Ideally, difference-in-differences analyses include 2 groups comparable to each other, especially in patient characteristics and how those characteristics are changing over time.

Some researchers used the difference-in-differences design to assign health systems, practices, or individual clinicians into categories based on telehealth use (high, medium, and low). The patients in this model were assigned to the clinicians before the COVID-19 pandemic. By focusing on patients' access to telehealth through their clinician, rather than patients' decision to use telehealth rather than an in-person visit, this study design attempts to mitigate selection bias stemming from patient characteristics and preferences.

A difference-in-differences framework was then used to compare the care in 2019 with the care in 2021, and then compare those changes across the high, medium, and low quintiles of telehealth use. In other words, researchers compared the changes in care among the high telehealth users with the changes in care among the low telehealth users to try to estimate the impact.

Data and Measurement Challenges

Similar to many other types of research, telehealth research must sometimes use data that are readily available rather than data that would best answer the research questions. It can be difficult to obtain good data on who is using telehealth and how it is being used. With the COVID-19 pandemic creating more opportunities to study telehealth, there has been a move away from RCTs and an increase in observational studies, which generally use claims or EHR data.

The clinical models many telehealth companies or other organizations use are often not well-aligned with claims or EHR data. For example, Firefly Health is a telehealth-only primary care practice that uses an app to exchange messages, reminders, and other communication with patients. These individual communications are not captured in claims or EHR data, which makes it difficult to directly compare Firefly Health with other primary care practices.

Available Evidence and Current Gaps

Quality of Care

The current research shows a lot of variation in the quality of telehealth services. Telehealth has been shown to improve quality of care and mortality in some applications, but many other

Pros and Cons to Using Claims and EHR Data

Claims data

- Relatively easy to identify telehealth visits using a combination of data elements
  - » Those data are not entirely reliable, especially before the COVID-19 pandemic and particularly for Medicare beneficiaries, which could undercount telehealth visits
- Often capture the entirety of a patient's health care use, allowing for a comparison of overall utilization and quality
- Difficult to reliably identify different telehealth modalities (e.g., audio-only, audio-video, remote patient monitoring)
  - » Data from surveys indicates more audio-only telehealth visits taking place than reported in claims or EHR data
- Do not capture telehealth visits paid for out-of-pocket or not covered by insurance

EHR data

- Depending on the quality or availability of the data, the modality of the telehealth encounter may be captured
- Depending on the quality or availability of the data, there is potential for examining variables not traditionally available in claims data, such as patient-level social risk, missed appointments, no shows, and primary language
- Do not capture care that takes place outside of that specific health care system

cases found telehealth leads to greater health care use yet no clear evidence it improves health outcomes. However, while research does not show large benefits associated with telehealth use, there are also not many harms.

Patient Satisfaction

A recent study shows most patients and physicians were glad telehealth was available during the COVID-19 pandemic and want it to be available in the future. However, 80% of physicians reported wanting a only small share of visits to be conducted using telehealth, while two-thirds of patients reported a preference for in-person care. The primary reason both physicians and patients reported these preferences is the lack of a physical exam with telehealth visits. In addition, most clinicians did not envision nor train for spending their day in virtual meetings when they began their career,

and may not have prepared for that shift in work.

Costs and Utilization

Telehealth does not appear to reduce health care spending. In some cases, spending is net neutral, while it is increased in others. There are several ways telehealth may impact overall health care use and spending. Research suggests telehealth services are mostly additive, inducing more health care use rather than replacing in-person visits. Some research shows the availability of virtual visits resulted in an over 80% increase in total visits across an enrollee population.

There could be potential longer-term decreases in spending if these trends are due to an increase in the number of patients able to access care. If telehealth leads to an increase in health care use and spending, the important question is whether or not the telehealth services improve access and value, and for which patients.

There are some concerns regarding over-billing and fraud with telehealth, but a recent US Office of Inspector General (OIG) report showed less than 1% of clinicians were billing telehealth visits at a high enough rate to pose some risk for fraud.

Health Disparities

There is an important emphasis on researching telehealth use by patient demographics, including race and ethnicity. However, the accuracy of data around race and ethnicity is often questionable. The available research generally shows when telehealth is offered to all patients, those who are more advantaged are more likely to use it, which could widen health disparities. There is not much research on why that is happening or what is driving it (e.g., access to technology). It is difficult to address exacerbation in disparities without understanding what is causing it. Are disparities addressed by changing how telehealth is delivered, or by offering telehealth in addition to other types of services?

Gaps in Telehealth Research

One gap in telehealth research is how telehealth is used under value-based payment models. Some recent evidence shows clinicians use more telehealth in capitated payment models compared with fee-for-service models. More research is needed in this area.

Another gap is whether the quality of telehealth visits varies between telehealth-only providers and traditional providers that offer some telehealth services. Should different types of telehealth visits be paid at different rates based on the value of the visit?

There is not a lot of research on the long-term outcomes associated with telehealth use for either patients or clinicians, because most telehealth research is cross-sectional and examines either single encounters or short timespans of encounters. In addition, there should be more intentional leveraging of natural variation in exposure to telehealth to enable large-scale natural experiments. Further study is needed on the impacts of telehealth use, including long-term impacts, access to broadband, and restrictions on practice across state lines.

Health policy changes usually happen over the course of decades, but telehealth policies changed very rapidly with the onset of the COVID-19 pandemic. It is going to take some time for telehealth research and practice to catch up to the telehealth policy changes. While many policymakers are searching for immediate answers, more telehealth research will emerge over the next couple years to inform some of the remaining policy questions.

STATE CASE STUDY: MARYLAND HEALTH CARE COMMISSION TELEHEALTH LEGISLATIVE STUDY

Presented by Alana Knudson, PhD - Director, NORC Walsh Center for Rural Health Analysis

Study Overview

The National Opinion Research Center (NORC), based at the University of Chicago, completed a study for the Maryland Health Care Commission (MHCC). The study was included in the Maryland General Assembly's Preserve Telehealth Act of 2021, and addressed research questions on access, health care use, costs, quality, and health equity. The study included 5 components:

- Literature review
- 78 consumer interviews, 8 conducted in Spanish
- 2 clinician and consumer behavioral health focus groups
- Online clinician survey with 1,083 participants representing somatic health and behavioral health providers
- Claims analysis using Medicare data from 2020, and Medicaid and commercial payer data from 2020 and 2021

Patient and Provider Perspectives

Through the interviews and focus groups, researchers found a common concern about being able to maintain audio-only and audio-video telehealth options. Consumers generally preferred audio-video technology but wanted the option to use audio-only technology in certain situations, such as when:

- There is no access to broadband, smartphones, tablets, or computers
- Consumers had limited expertise with technology, or difficulty using the technology
- Sensitive topics were being discussed, particularly during behavioral health visits

Consumers identified several advantages to telehealth, such as convenience, agency in selecting a provider, protection of privacy, and feeling "more heard" by providers. Another advantage was a reduction in barriers to accessing care, such as transportation costs, wait times, and distance to clinicians (especially for those with mobility challenges).

Most clinicians (77%-100%) felt audio-only and audio-video telehealth increased access to care. Somatic health clinicians were less likely than behavioral health clinicians to report feeling audio-only telehealth increased access to care, especially for patients with cognitive disabilities. Nevertheless, 77% of somatic health providers still felt it did.

Both somatic and behavioral health clinicians indicated their greatest barriers to using telehealth were low reimbursement (from commercial payers, Medicare, and Medicaid) and the different payer rules for telehealth.

Telehealth Use

The NORC study primarily used claims data and the clinician surveys to evaluate telehealth utilization. Findings from these analyses showed people living in urban areas used more telehealth services compared with those living in rural areas. Younger individuals (27-49 years old) also were more likely to use telehealth services than older individuals (75 years and older). Less likely to use telehealth services were individuals with limited English language proficiency.

Of the 3 payer types analyzed (Medicaid, Medicare, and commercial payers), Medicaid had the highest use of evaluation and management telehealth services. Commercial payers had the lowest use of these services. When examining overall somatic care among all payers, there was an initial spike in telehealth use at the beginning of the COVID-19 pandemic, which leveled off by fall 2020 to a rate higher than prepandemic levels but lower than in early 2020. Behavioral health care showed a much larger spike in telehealth use at the beginning of the COVID-19 pandemic, and telehealth use remained high throughout 2021.

Costs

According to findings from the interviews and focus groups, consumers believe telehealth may reduce costs due to increased convenience,

particularly with regard to transportation costs. Consumers also reported enjoying the experience of being able to receive care from home, and when providers waived copays. Consumers said telehealth allowed them to maintain preventative care and avoid urgent care and emergency department visits, which also helped eliminate related copays.

Many consumers were unsure about coverage and reimbursement. Since some telehealth services require an in-person follow-up visit, consumers reported concerns about increased out-of-pocket costs and the potential negative consequences of delaying care.

Behavioral health focus group participants (both consumers and clinicians) highlighted the importance of telehealth's ability to provide immediate access to care during a mental health crisis, which may be life-saving, while avoiding urgent care and emergency department visits.

Participants also reported telehealth potentially reduces no-show rates and hospitalizations. Focus group participants strongly recommended payment and coverage parity for both audio-only and audio-video services.

Data Challenges

It was difficult for researchers to discern the difference between audio-only and audio-video services in the Medicaid and commercial payer claims data, and researchers were only able to differentiate between those modalities in the Medicare data toward the end of 2020. In addition, 70% of the claims were missing race and ethnicity data.

Conclusions

- Consumers and clinicians valued the option of audio-only and audio-video technologies to complement, rather than replace, in-person care

- The behavioral health focus groups were very committed to payment parity for audio-only and audio-video telehealth visits

- Additional claims data analyses are needed to determine whether telehealth services were cost effective, what the quality of those services were, and what role those services played in advancing health equity

Recommendations

The MHCC made the following recommendations as a result of the findings from this study:

- Allow use of telehealth, including audio-only visits when audio-video visits are not feasible

- Allow remote patient monitoring

- Require clinicians to use technology compliant with privacy and security requirements

- Allow hospice services, hospital inpatient settings, and nursing homes to use telehealth

- Continue payment levels for telehealth services for 24 months, and require MHCC to conduct a study examining payment parity for audio-only and audio-video technologies

CLOSING REMARKS

Presented by Jonathan Neufeld, PhD, HSPP Director and Principal Investigator, Great Plains Telehealth Resource and Assistance Center

Assessing Telehealth Quality

There are multiple levels at which telehealth quality can be assessed, including the individual visit, patient, clinic or site, target population, and health system. The research questions and the data needed for answers vary depending on these levels and other factors. The scope of telehealth is very large and the term "telehealth" is used in many different ways, making the broader question of whether telehealth is effective somewhat irrelevant. Instead, researchers need to examine how telehealth is being implemented and what models are being used.

Research Challenges

It is challenging to make direct comparisons in telehealth use between states, payers, or health systems when telehealth is coded differently. Increased consistency and guidance around telehealth billing and coding will be helpful for both researchers and regulators. In addition, it will be important to find ways to characterize beneficial and adverse telehealth use. For example, an increase in health care use may not necessarily be bad if it is the result of increased access to care.

Health Equity

Research shows telehealth is used inequitably. Since the broadband and health care infrastructures in the US are fundamentally

inequitable and telehealth is dependent on those infrastructures, telehealth will likely remain inequitably distributed until the underlying infrastructures issues are addressed.

Telehealth Innovations

Telehealth delivery evolves over time with the goal to improve the way telehealth is accessed and delivered. Telehealth providers will innovate if given the opportunity, and it will be important to avoid stifling that innovation through regulation.

Research suggests there are not many harms associated with telehealth use. Therefore, there may not be much risk in allowing innovations in telehealth delivery and taking the time to explore and research how those innovations develop. It is also important to consider factors such as the different motivations of telehealth-only businesses compared with traditional providers that offer some telehealth services.

AUTHORS/PROJECT TEAM

AMELIA HARJU, MPH
Policy Analyst
Amelia Harju is a Policy Analyst at the Center for Evidence-based Policy. She conducts research to inform policy decisions for the Medicaid Evidence-Based Decisions Project (MED). Amelia also serves as the Research Lead for MED's eHealth Workgroup.

ALLYSON EVANS, JD
Policy Director
Allyson Evans is the Policy Director, and Director, of the MED Project at the Center for Evidence-based Policy. She oversees policy research methods across research projects at the Center.

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