



Equity in Telehealth Policy

A framework to evaluate how policy can support the use of telehealth to improve health equity in MCH public health systems.



OVERVIEW

The COVID-19 pandemic has been a catalyst for telehealth implementation in public health systems and has shown how critical virtual service delivery can be for MCH populations during times of crisis and beyond. From perinatal care and family planning services to home visiting and newborn screening, telehealth helps ensure that individuals and families receive safe, timely, and high-quality care when and where they need it. AMCHP defines telehealth as the remote delivery of health care services and clinical information via telecommunications technology. Telehealth can include, but is not limited to, appointments with health care providers, family education, and peer-to-peer support. Since the onset of the pandemic in the United States in March 2020, states and jurisdictions have enacted numerous policies and emergency regulations targeting telehealth to reduce barriers for families and providers. This response has shown that telehealth policy has the potential to expand access to support and services within MCH public health systems and meaningfully advance health equity.

As policymakers and the public begin to plan for life after the pandemic, MCH public health systems have an opportunity to determine whether telehealth policies developed in response to the public health crisis should remain in effect. In doing so, it is critical that MCH professionals have a framework with which to assess the equity implications of these policies in the immediate future and in the event of additional public health crises that may impact MCH populations. In this brief, AMCHP offers a definition for equity in telehealth, describes the four dimensions of equity in telehealth policy, and provides case study examples of how these dimensions can be applied when assessing the equity impacts of a given telehealth policy solution.





WHAT DOES EQUITY IN TELEHEALTH LOOK LIKE?

Equity in telehealth means that all individuals have a fair and just opportunity to access care in a virtual format that is tailored to their needs. AMCHP defines “access” as those having the necessary equipment, network capacity, accommodations, and financial means to receive services or support through telehealth. While telehealth should be made available to all individuals, equity in telehealth means focusing efforts on improving access for those with the highest need, specifically those who experienced barriers to receiving in-person care prior to the pandemic and individuals from historically marginalized and oppressed communities including Black, Indigenous, and People of Color (BIPOC).

To further describe what equity in telehealth looks like, AMCHP has developed four dimensions of equity that should be prioritized in telehealth policy.

FINANCIAL ACCESS

A policy should prioritize increasing the financial accessibility of telehealth services for individuals and families. For example, a policy that reimburses providers for telehealth services with parity, meaning the same amount as an in-person visit, may reduce costs for families by ensuring there are no additional out of pocket expenses for necessary care received via telehealth.

QUESTIONS TO CONSIDER

1. Does the policy broaden the scope of reimbursable telehealth services that families can access?
2. Are the cost savings from the policy to the family and/or to the provider?

EQUIPMENT & CAPACITY

A policy should either directly or indirectly address the need for telehealth equipment for individuals and families including devices such as tablets and cellphones, platforms to connect with service providers, and connectivity such as cellular service and broadband internet access. For example, a policy that ensures that families can receive reimbursable care via telephone (audio only) when appropriate ensures that those with limited or no internet access can still receive care.

QUESTIONS TO CONSIDER

1. Does the policy allow reimbursement for audio only or audio/visual visits?
2. Does the policy allocate funds that can be used to acquire necessary equipment for telehealth for individuals and families?
3. Does the policy support providers in acquiring necessary equipment and software to deliver telehealth services?
4. Does the policy expand access to broadband for communities?

ACCESSIBILITY OF CARE

A policy should increase the appropriateness and accessibility of care for individuals and families who may need specific accommodations to receive telehealth services. These accommodations may include interpretation, culturally appropriate care delivery, and reasonable accommodations as defined by the ADA. A policy that ensures families have access to an online interpreter to communicate with their provider during virtual visits is an example of a policy that increases the appropriateness of care.

QUESTIONS TO CONSIDER

1. Does the policy increase access to technology that meet the population's specific telehealth needs?
2. Does the policy account for technology needs of individuals with disabilities including being deaf or hard of hearing?

HIGH-NEED POPULATIONS

A policy should prioritize expanding access to services for individuals who experienced barriers to receiving in-person care prior to the pandemic and individuals from historically marginalized and oppressed communities including Black, Indigenous, and People of Color (BIPOC). For example, a policy that specifically highlights establishing broadband connectivity for tribal communities would be prioritizing a high-need and historically oppressed community. A policy that prioritizes high-need populations could also include expanding access to types of providers such as doulas and community health workers that have been shown to provide culturally appropriate care for BIPOC communities.

QUESTIONS TO CONSIDER

1. Are BIPOC communities prioritized in how resources are allocated by the policy?
2. Does the policy increase access to equipment and care to communities that did not have access to these entities prior to the policy?

MCH professionals can use these dimensions to assess the degree to which existing and future telehealth policies promote equity for individuals and families. The following case studies are examples of how these dimensions can be used to consider the ways in which a telehealth policy promotes equity, as well as opportunities for ways a policy can be modified to further advance health equity.

NORTH CAROLINA ALLOWING FOR TELEHEALTH FAMILY PLANNING SERVICES FOR MAFDN BENEFICIARIES

NORTH
CAROLINA



TYPE OF POLICY
Medicaid

FOCUS AREA
Family Planning Services

TARGET POPULATION
Medicaid Beneficiaries

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POLICY DESCRIPTION AND IMPACT

In light of social distancing measures that prevented in-person visits, in May 2020 North Carolina Medicaid temporarily enabled eligible providers (physicians, nurse practitioners, physician assistants, and certified nurse midwives) to deliver and be reimbursed for family planning services to NC “Be Smart” Family Planning Medicaid program (MAFDN) eligible beneficiaries via telemedicine (two-way real-time, audio and visual) or virtual patient communication (telephone call only). Notably, this policy expanded access to care for high-need populations by making both new and established MAFDN patients eligible to receive services. With that said, only established patients were able to receive audio only services.

This policy also expanded access to care by waiving the need for new and established MAFDN-eligible beneficiaries to have an annual physical exam before receiving these services. This ensured that new MAFDN-eligible beneficiaries could receive timely family planning services during the pandemic. Furthermore, patients were not required to obtain prior authorization before receiving services and providers could submit claims without a patient’s annual exam date.

EQUITY DIMENSIONS ADDRESSED

[Learn more](#) about these dimensions and how telehealth can improve health equity for families during the pandemic and beyond.



FINANCIAL
ACCESS



EQUIPMENT
& CAPACITY



ACCESSIBILITY
OF CARE



HIGH-NEED
POPULATIONS

OPPORTUNITIES TO FURTHER ADVANCE EQUITY

Equipment & capacity: While 94.2% of North Carolinians live in areas with broadband internet coverage sufficient for audio and visual telehealth (100mbps or faster), there is considerable variation in county-level access to broadband with Hyde county having only 16.8% broadband coverage. Given these differences in access, amending this policy to allow for both existing and new MAFDN beneficiaries to receive telephone only services would ensure that individuals without broadband coverage would still be eligible to receive services.

ALASKA ALLOWS PROVIDERS TO HIRE FAMILY CAREGIVERS AS DIRECT SERVICES WORKERS

ALASKA



TYPE OF POLICY
Medicaid

FOCUS AREA
Disabilities Services

TARGET POPULATION
CYSHCN

[View Full Policy Text](#)

POLICY DESCRIPTION AND IMPACT

In Alaska, COVID-19 has disproportionately impacted the populations served under its 1915(c) Home and Community-Based Services (HCBS) waivers, older adults and individuals with underlying health conditions. The waiver allows providers to hire family caregivers as direct service workers for respite care, supported living services and in-home supports. The Senior and Disabilities Service Division (SDS) anticipated the following changes to service delivery: services being provided in different settings, including services previously provided in the community being provided in private homes and alternative settings; waiver services being provided in acute settings so that support can be provided by someone familiar with the participants' specific needs; substitutions across services, such as respite being used instead of day habilitation; the need for more units of service when a participant has an active infection or if a paid caregiver becomes infected or quarantined; and services being provided telephonically or via telemedicine to minimize the need for unnecessary in-person contact.

These policy changes expanded access to telemedicine and support services for Medicaid beneficiaries, specifically those served under the 1915(c) HCBS waivers. This will have a positive impact on this population as beneficiaries will have increased access to quality and equitable healthcare.

EQUITY DIMENSIONS ADDRESSED

[Learn more](#) about these dimensions and how telehealth can improve health equity for families during the pandemic and beyond.

FINANCIAL ACCESS	EQUIPMENT & CAPACITY	ACCESSIBILITY OF CARE	HIGH-NEED POPULATIONS

OPPORTUNITIES TO FURTHER ADVANCE EQUITY

Accessibility of Care: Modifying this policy to include specific procedures to ensure the populations served under the 1915(c) HCBS waivers have sufficient access to appropriate equipment to participate in telehealth visits.

WASHINGTON STATE HEALTH CARE AUTHORITY OFFERS LIMITED FREE ZOOM LICENSES TO PROVIDERS

WASHINGTON



TYPE OF POLICY
Medicaid

FOCUS AREA
Technology

TARGET POPULATION
Providers

[View Full Policy Text](#)

POLICY DESCRIPTION AND IMPACT

In response to the COVID-19 pandemic and the increased utilization of telehealth, the Washington State Health Care Authority (HCA) purchased a limited number of Zoom licenses for health care providers to use when seeing patients. These licenses were distributed free of charge to providers who were in need of a platform to continue providing care to their patients and for those who did not have access to other telehealth technology.

HCA prioritized Zoom licenses for those providers most in need, including those who: serve a large number of Medicaid beneficiaries; do not already have other HIPAA or 42 CFR Part 2 (privacy protections for the treatment of substance use disorders)-compliant video capabilities; are in smaller practices with less infrastructure; serve children, adolescents, pregnant or parenting women or tribal members; are primary care providers; or are licensed behavioral health professionals or paraprofessionals.

This policy addresses both equipment and capacity as well as high-need populations by prioritizing Medicaid beneficiaries and increasing access to equipment and capacity for providers who serve them. The implementation of this policy allows for more providers to provide virtual healthcare to their patients which results in patients having more options and availability of healthcare services.

EQUITY DIMENSIONS ADDRESSED

[Learn more](#) about these dimensions and how telehealth can improve health equity for families during the pandemic and beyond.



FINANCIAL
ACCESS



EQUIPMENT
& CAPACITY



ACCESSIBILITY
OF CARE



HIGH-NEED
POPULATIONS

OPPORTUNITIES TO FURTHER ADVANCE EQUITY

Prioritize high-need populations: Modifying the current policy to increase the number of no-cost Zoom licenses available to primary care providers serving Medicaid populations.

CONNECTICUT EXTENDS BIRTH-TO-THREE SERVICES FOR CHILDREN DURING THE PANDEMIC

CONNECTICUT



TYPE OF POLICY
Executive Order

FOCUS AREA
Early Intervention

TARGET POPULATION
Children Ages 0 to 3

[View Full Policy Text](#)

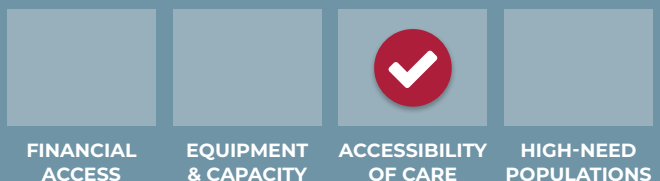
POLICY DESCRIPTION AND IMPACT

The cancellation of in-person school classes and compliance with COVID-19 protective measures may have caused a delay in needed face-to-face assessments to determine eligibility of young children for Part B Individuals with Disabilities Education Act (IDEA) Services. For toddlers who would age out of their current Birth-to-Three services during the pandemic, these delays in needed assessments could have resulted in a critical services gap. In response to this need, Connecticut Governor Ned Lamont issued an executive order which allowed for a temporary expansion of the definition of “eligible children” for Birth-to-Three services to include children older than 36 months who were already engaged in early intervention services and had not yet been deemed eligible for IDEA Part B Services. The policy stipulated that the Commissioner of the Office of Early Childhood could issue any order necessary to implement this policy, and that it shall remain in effect for the duration of the public health emergency.

Continuing remote early intervention services for children who would have otherwise aged out of their Birth-to-Three services, but did not have access to the necessary eligibility assessments for subsequent Part B IDEA services, ensures that children in need of services will not experience a service gap due to COVID-19. Modifying this age requirement also limits in-person contact related to such assessments and observations, and thereby reduces the risk of transmission of COVID-19.

EQUITY DIMENSIONS ADDRESSED

[Learn more](#) about these dimensions and how telehealth can improve health equity for families during the pandemic and beyond.



OPPORTUNITIES TO FURTHER ADVANCE EQUITY

Equipment & capacity: Amending this policy to delineate specific measures to ensure that children who will continue to receive Birth-to-Three services have access to the telehealth equipment needed to access services during the pandemic.

Prioritize high-need populations: Amending this policy to also expand access to children who started receiving Birth-to-Three services during the pandemic, but would also age-out of these services over the course of the prolonged pandemic, would ensure that children who did not have access to services prior to the pandemic could receive the same benefits as those who were previously accessing these services

MINNESOTA TEMPORARILY EXTENDS TELEHEALTH ELIGIBILITY TO MCH PROVIDERS

MINNESOTA



TYPE OF POLICY
Administrative

FOCUS AREA
Telehealth Eligibility

TARGET POPULATION
Providers

[View Full Policy Text](#)

POLICY DESCRIPTION AND IMPACT

In March 2020, the Minnesota Department of Human Services allowed for temporary changes to eligible telehealth providers and practices in order to reduce COVID-19 transmission and ensure Minnesota families continued to have access to critical care and support services during the emerging pandemic. The policy included several changes targeting barriers for individuals and families to receive care virtually. One such change was extending temporary eligibility to certain providers to provide care via telehealth or telephone. This new list included doulas (for pre and postnatal care), community health workers, and equivalent tribal providers, who were previously ineligible. The policy also temporarily eliminated face-to-face contact requirements for Indian Health Services child welfare and mental health case managers in favor of telephonic visits.

While these allowances have an impact on telehealth access for all families, they have powerful equity implications for high-need populations, including Black, Indigenous, and People of Color (BIPOC). Having a provider who is a member of one's own community has been shown to reduce disparities among these groups and improve health outcomes for individuals and families, making them a critical part of the MCH public health system. This is especially true during the pandemic, which has disproportionately impacted communities of color, as families navigate new health systems and isolation in their communities.

EQUITY DIMENSIONS ADDRESSED

[Learn more](#) about these dimensions and how telehealth can improve health equity for families during the pandemic and beyond.



OPPORTUNITIES TO FURTHER ADVANCE EQUITY

Prioritize high-need populations: This policy could further address this equity dimension by extending these temporary eligibilities. In addition to the important role providers such as doulas and community health workers play in the care team, nonclinical services such as health education, care coordination and social support are also well positioned for long-term virtual service delivery. Extending telehealth eligibility to these providers beyond the public health emergency would advance health equity and allow families to receive culturally competent care from a member of their community, regardless of where they live or other barriers to in-person services.



LEARN MORE

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