



Medicaid Principles on Telehealth

A. Introduction - Understanding telehealth

Telehealth is the use of digital technologies to deliver health care, health information, and other health services by connecting two or more users - principally the patient and the provider - in separate locations. The patient is located at the “originating site” and the provider is located at the “distant site.” Telehealth includes diagnosis, treatment, assessment, monitoring, communications, and education. While some use the terms “telehealth” and “telemedicine” interchangeably, this document will solely employ the term “telehealth.” Telehealth is used to reflect a broader definition, while “telemedicine” is used mainly to define the delivery of clinical services.

B. The Telehealth Promise

The COVID-19 pandemic has highlighted the importance of telehealth in delivering critical health care when patients are not able to receive services in person. Several states are working to ensure that their residents, including Medicaid enrollees, have access to the services they need during this critical time. Long before this public health emergency, the use of telehealth has been dramatically rising and it is becoming part of the mainstream health care system.¹ Evidence shows that when patients use telehealth services, access to care improves.² Studies also demonstrate that under certain circumstances the quality of services delivered via telehealth is not different from the quality of services provided in person.³ For example, researchers of a pilot study implemented in multiple states have found that colposcopies performed via telehealth were just as effective at predicting cervical cancer as traditional colposcopies.⁴ Furthermore, the study’s patients reported high levels of satisfaction with the telecolposcopy. In fact, after the experiment was concluded, patients were given the option of traveling to have the colposcopy performed in person or continuing to receive services via telehealth, and almost all chose the second option.

Because of provider shortages, rural areas would particularly benefit from telehealth investment and utilization. According to the National Center for Health Statistics, the primary care physician-to-patient ratio in rural areas is 39.8 physicians per 100,000 people, compared to 53.3 physicians in urban areas.⁵ In these communities, the nearest medical center is often over twenty miles away. Provider shortages in rural areas are particularly acute among specialists. For instance, rural communities face wait times of three to six months to see a psychiatrist when telepsychiatry could significantly shorten these wait times.⁶ These disparities are likely to worsen as hundreds of rural hospitals close every year.⁷

Access to health care can also be a significant challenge for individuals who reside in non-rural areas with limited public transportation options, as well as for those who have difficulty leaving children and jobs in order to see a provider. Transportation barriers have an adverse impact on communities of color and people with low incomes in particular. Nineteen percent of African-Americans and 13.7 percent of Latinxs lack access to automobiles compared to 4.6 percent of whites. Poverty compounds the problem: thirty-three percent of low-income African-Americans, twenty-five percent of low-income Latinxs, and 12.1 percent of low-income whites lack automobile access.⁸ Similarly, telehealth can be beneficial to indigenous communities who reside in isolated areas with provider shortages, veterans who often move from one military station to another, and people who are incarcerated and have limited access to services.

In the realm of reproductive and sexual health care, where privacy, timeliness, and discretion are paramount, telehealth has provided greater access to care. Research shows that medication abortions provided via telehealth - also known as telabortion - essentially have the same health outcomes as medication abortions provided in a clinic or other medical setting.⁹ Telabortions are also as safe as the standard, in-person provision of medication abortions.¹⁰ Because of telehealth's significant potential to increase access to reproductive health services, the American College of Obstetricians and Gynecologists urged their members to collaborate with rural health agencies and advocate for telehealth as a way to improve disparities in obstetric and gynecological care in rural settings.¹¹

Telehealth can also be beneficial for people with disabilities, including children. For example, the Children's National Health System in the District of Columbia expanded its use of telehealth for virtual home visits to improve care for children with medical complexities. Telehealth is used for direct medical visits (particularly with technology-dependent children) for both post-discharge and interim visits as well as joint visits involving child, parent, and other participants like primary and complex care providers, case managers, care coordinators, home care nursing services and parent navigator partners. The program is receiving reimbursement from some Medicaid MCOs for telehealth visits.¹²

Even before the COVID-19 pandemic, opinion polls demonstrated that willingness to use telehealth services was high across generations.¹³ Of those who were surveyed, sixty-six percent would like to use telehealth and eight percent have tried it. Polls also indicated that fifty million U.S. residents would switch their family practice providers to have access to video visits.¹⁴ With the COVID-19 pandemic, this number will significantly increase. Similarly, participants of a teleabortion study noted that telehealth allowed them to schedule appointments around their lunch times or to schedule the visits sooner and avoid a delay in services.¹⁵ Patients also noted that telehealth permitted them to see the provider privately, whereas an in-person visit would have required them to see the provider in a group setting where they risked revealing personal information. Some patients were especially concerned about attending clinics near their homes due to perceived stigma. For these individuals, telehealth was a much better service delivery option than in-person care.

C. Why Telehealth Matters for low-income and underserved populations

Although individuals increasingly use telehealth in both public and private insurance coverage, it is mostly patients with resources—including private insurance enrollees—who are taking advantage of telehealth services. Studies demonstrate that underserved populations—such as low-income, rural, and Medicaid populations—are not using telehealth as widely as other demographic groups.¹⁶ Long before the COVID-19 pandemic, states and providers had begun to develop innovative initiatives to address these disparities. For example, the Marshfield Home Recovery program in Wisconsin had successfully secured Medicaid reimbursement for its telehealth program.¹⁷ By combining home visits by a nurse, communication with a physician over a computer tablet, and daily readings of weight, blood pressure, and temperature, the program was able to serve 250 patients and treat 150 conditions. Following the implementation of the telehealth program, hospital readmissions went down forty-four percent and patient satisfaction increased by twenty-two percent.

As the COVID-19 pandemic has demonstrated, Medicaid-eligible and other underserved individuals should be able to benefit from telehealth's promises. Before the COVID-pandemic, all fifty states and the District of Columbia provided reimbursement for some form of live video visits in Medicaid Fee-For-Service.¹⁸ Yet, telehealth policies varied by state, including in their definition of telehealth, how they covered services, and which providers they reimbursed. In the wake of the public health emergency, states have aggressively increased telehealth coverage in Medicaid. Thanks to new CMS guidance in response to COVID-19, states will expand and standardize Medicaid reimbursement.¹⁹ These measures will contribute to its utilization and benefit the Medicaid population.

Much has been written about Medicaid and the advantage telehealth presents for plans' return-of-investment, but little exists about the impact on consumers. As described in the 2018 Medicaid and CHIP Payment and Access Commission (MACPAC) Report to Congress on Medicaid and the Children's Health Insurance Program (CHIP), states seeking to implement or expand coverage of telehealth would benefit from additional research on the use of telehealth for the Medicaid population.²⁰ The increased use of telehealth during the COVID-19 pandemic and states' efforts to cover them via Medicaid also offers the opportunity to evaluate its effects on enrollees.

For low-income individuals to also gain from the technological advances that allow for service delivery by telehealth, Medicaid laws must be updated and resources must be allocated for consumers' connectivity and adequate devices. Because telehealth laws vary so much from state to state, developing a set of baseline rules and principles for its use is important. It is also critical to acknowledge that telehealth should not replace in person health care, but instead complement or add to the existing services. While telehealth is not the only solution for limited access to health care, it should be considered as part of a long-term, complementary, and sustained strategy to address problems regarding access and convenience for the consumer.

D. Medicaid Principles on Telehealth

Principle # 1: Telehealth should be accessible and equitable to all Medicaid recipients

Telehealth should be available to everyone, irrespective of their race and ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, immigration status, nationality, religious beliefs, language proficiency, or geographic location. At a minimum, telehealth services must comply with all existing civil rights laws, including but not limited to, Section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act, the Age Discrimination Act, and the Americans with Disabilities Act.

Unless deemed necessary by the telehealth provider, telehealth interactions should not go through additional hoops that are not required for the in-person delivery of those services such as prior authorization or an initial in-person visit. All populations should have the resources and support to have the highest quality of care available through a telehealth interaction.

Principle # 2: Services offered as telehealth benefits must also be available to the patient in-person, and neither modality should be sacrificed for the other.

Patients retain the right to receive health care in person. They should not be forced to use a telehealth modality if they want and need to use a health care service in person. No plan policy or practice should discourage in-person visits, such as increasing copayments for in-person visits compared with a telehealth visit. The prudent layperson standard in health care service

continues to apply under telehealth, requiring health insurance companies to cover visits based on the patients' presenting symptoms rather than their final diagnoses.

The use of telehealth should not derail network adequacy and other managed care protections.²¹ Managed care plans must not require patients to utilize telemedicine in lieu of receiving in-person services from an in-network provider when there is not a public health emergency. Managed Care plan enrollees as well as Fee-For-Services enrollees have the right to the same types of services, providers, cost-sharing requirements, and telehealth modalities. Furthermore, states should prohibit plans from meeting network adequacy requirements through significant reliance on services offered via telehealth, unless there is a public health emergency.

Principle # 3: Standard of care should apply to telehealth services.

Standard of care requirements continue to apply to health care, supplies, and information provided via telehealth. As such, Medicaid plans must reimburse health care providers for telehealth services when the provider can ensure those services meet standards of care. Additionally, health care professional boards and associations should adopt telehealth practice standards for their member providers.

Services delivered via telehealth must be based on either clinical evidence and/or the provider's best professional judgment that those services can be delivered using telehealth modalities. The standards of practice for services rendered through telehealth should be the same as services provided in person. Under current scientific possibilities, telehealth cannot include services taking place in the operating room or while the patient is under anesthesia, where direct visualization or instrumentation of bodily structures is required, or procedures that involve sampling of tissue or insertion or removal of medical devices.

As with in-person services, services delivered through telehealth should be culturally competent and linguistically appropriate. To this end, language interpreters should also be available to individuals accessing care through telehealth. Furthermore, telehealth providers should also spend time reassuring and educating beneficiaries about the safest and most pertinent medical interventions that are appropriate for their care.

Principle # 4: Individuals retain the right to make informed decisions when receiving telehealth services.

Telehealth can offer patients the opportunity to empower themselves through self-education and managing the delivery of their own health care. In this sense, patients and providers are equal parties in the decision-making process. This equity in decision-making should apply not only to the decision about whether to use telehealth, but also the decision to continue using it during the course of treatment.

Principle # 5: Patient's confidentiality should be protected during telehealth interactions, and the patient should provide informed consent in writing or verbally.

Telehealth services are subject to federal and state privacy and confidentiality laws, including the Health Insurance Portability and Accountability Act (HIPAA). All verbal, visual, written, and other communications involved in the delivery of telehealth services in the originating and distant sites must be protected and use encrypted connections. Providers and patients should have the Information Technology (IT) support to have secure connections. Further, transitions and operability between medical records, including electronic health records, and telehealth technologies should be seamless.

In addition, all forms of consent—written, visual, and oral—must be available during telehealth interactions. A documented, general consent to the use of telehealth before the health care intervention occurs should be sufficient. A healthcare provider at the originating or distant site can maintain a general consent agreement that addresses the use of telehealth. The documentation of patient consent must be kept in the patient's medical file and the patient retains the right to own their medical information of all telehealth interactions.

Principle # 6: Services delivered via telehealth must be reimbursed at the same rate as services delivered in person.

Medicaid and Managed Care plans must reimburse a health care provider for all diagnoses, consultations, or treatments performed through telehealth services at the same rate and to the same extent that Medicaid or the Managed Care health plan reimburse for the same service through in-person diagnosis, consultation, or treatment.

Medicaid and Managed Care plans should not create barriers that limit access to telehealth like imposing an annual or lifetime dollar maximum for telehealth services, establishing minimum distance requirements, or requiring a deductible, copayment, or coinsurance or other durational benefit limitation or maximum for benefits or services that are not equally imposed on all terms and services covered in-person. Medicaid reimbursement should also be available

regardless of the type of the patient's or provider's location - whether in a rural, urban, or sub-urban area.

Principle # 7: Medicaid should reimburse every telehealth provider.

A patient-provider relationship can be established via telehealth; therefore, an in-person interaction should not be required to receive Medicaid reimbursement.

Medicaid should reimburse telehealth providers irrespective of their location. Providers do not need to be in the same state where the patient is located. They only need to be licensed in the patient's state and participate in that state's Medicaid program and be in good standing. The provider can also be part of a compact between the provider's state and the state where the patient resides. In this vein, states can engage in multi-state agreements like the Nurse Licensing Compact, which allows a nurse with a license in a compact member state to practice in another compact member state without having to obtain another state license. Another model is the Federation of State Medical Boards' Interstate Medical Licensure Compact, which allows an expedited licensure process for providers to apply for licenses in other states. States can also allow temporary licenses while licensing conditions are in the process of being met. Providers who are registered through these compacts are subject to all the federal laws as well as the laws and duties of the states of each compact state where the providers choose to practice. State boards participating in the Compact are required to share professional complaint and investigate information with one another.

All Medicaid providers who offer services that can be delivered via telehealth should be reimbursed. These providers include, but are not limited to, physicians, certified nurse practitioners, certified nurse midwives, dentists, occupational therapists, pharmacists, physical therapists, clinical social workers, speech-language pathologists, counselors, audiologists, as well as dietitians and nutrition professionals. Prescriptions - including those issued by pharmacists - should be reimbursed if administered through telehealth technologies. Medicaid should also reimburse telehealth providers who offer services in federally qualified health centers and rural health centers.

Telehealth can also support coordinated health and related services on an ongoing basis from a multidisciplinary set of providers. For example, the TeleFamilies Project, run by the University of Minnesota, used video conferences to increase care coordination to children with high levels of medical complexity.²² Research that studied this project revealed that telehealth encounters among multiple practitioners prevented clinic visits and Emergency Department visits.

Principle # 8: Medicaid should cover a telehealth patient located at any site.

The patient can be located in any originating site, including, but not exclusively, the home, school, community health center, homeless shelter, etc. A provider does not need to be present at the originating site unless the patient requests such service. Reimbursements should be made to both distant (where the attending provider is located) as well as originating sites (where the patient is located, if another provider accompanies the patient).

Principle # 9: The federal government and the states should make significant investments in the development of telehealth technologies, focusing on organizations and providers that serve low-income and underserved populations.

State and federal investment should be made on applications, security software, high-speed broadband connections, as well as equipment - including webcam-enabled workstations and internet routers. The originating and distant sites should have access to IT support. CMS should authorize enhanced Medicaid administrative matching rates for development and implementation of telehealth options.

Removing barriers—particularly financial ones—to using telehealth will also be necessary for telehealth to be effectively available to low-income populations. This might include the provision of affordable broadband through the Federal Communications Commission's Lifeline program, or purchasing needed equipment such as smartphones or tablets (as well as data plans or internet access) to support telehealth visits.

Principle # 10: Medicaid programs should incentivize the utilization of telehealth through patient and provider education and training.

Even when telehealth service is available, consumers might not know how, when, and where to use it.²³ In order to truly level the playing field on telehealth utilization, it will be critical to conduct extensive public outreach, including trainings and awareness campaigns among providers, their support staff, and communities. Enhancing consumer education in underserved communities could significantly increase telehealth use and overall access to health care services in underserved populations. Providers and their staff should be continuously educated on the advantages and technologies that facilitate telehealth – keeping the patients' interests in mind.

Principle # 11: Medicaid programs should cover all types of telehealth modalities that will support the delivery of care for the patient.

Providers and patients should decide the type of modality that is best for the patient's health care. Medicaid should offer reimbursement for all modalities, including:

- Live Video (Synchronous): This is the most commonly-used telehealth modality.
- Store-and-forward (Asynchronous): This involves the electronic transmission of medical information—such as digital images, documents, and pre-recorded videos—in order to aid in diagnoses and medical consults. Asynchronous transmissions typically do not occur in real-time.
 - One type of asynchronous communication involves e-consults, where health care providers engage in email consultations with each other regarding a particular patient through a secure email system. A patient's treating health care provider requests the opinion and/or treatment advice of another health care practitioner with specific expertise to assist in the diagnosis and/or management of the patient's health care needs. E-consults between health care providers are designed to offer coordinated multidisciplinary case reviews, advisory opinions, and recommendations of care.
- Remote Patient Monitoring: RPM involves the use of telehealth technologies to collect medical data, such as vital signs and blood pressure, from patients in one location in order to electronically transmit that information to health care providers in a different location.
- mHealth: This involves the delivery of healthcare services via mobile devices, such as smartphones, tablets, and patient monitoring devices, and personal digital assistants.
- Telephonic communications: In situations where the enrollee lacks access to smartphones, tablets, or similar devices and it is clinically appropriate, the patient should receive coverage for services offered through the phone as well as chat modalities. Such coverage would particularly benefit people of color since African-Americans and Latinxs are more likely to access the internet through mobile devices.²⁴

Principle # 12: Medicaid policies should be written with current technologies in mind and should be continuously updated to accommodate for developments in telehealth technologies.

Any advances on telehealth technology should be reflected in policy updates. For example, efforts are already underway to facilitate the testing and treatment of sexually transmitted infections and urinary tract infections using telehealth since rural and underserved communities often lack the medical experts needed to diagnose and treat cervical cancer.²⁵ Therefore, the use of those emerging technologies and the telehealth services should be reimbursed by Medicaid. To address any issues with billing and coding across Medicaid, CMS should issue guidance on telehealth outlining a set of billing codes, modifiers, and/or place of service designations for use in State Medicaid programs.

Principle # 13: Medicaid programs should incentivize additional research and data collection on the actual benefits to underserved populations, including Medicaid beneficiaries.

As described in the MACPAC Report, states seeking to implement or expand coverage of telehealth would benefit from additional research on the use of telehealth for the Medicaid population, including detailed demographic data like race, age, geographic location, existence of a disability, etc.²⁶ The rise of telehealth use during the COVID-19 pandemic offers such opportunity. A study by the Agency for Healthcare Research and Quality also noted that more research should be done about telehealth, such as triaging for urgent care, consultations, and maternal and child health.²⁷ In particular, additional research on the impact of telehealth on access for low-income consumers and their health outcomes should be undertaken.

E. Conclusion

Telehealth can help Medicaid eligible low-income and underserved populations gain better access to providers, while safeguarding their privacy and offering a more convenient option to access health care. Telehealth is rapidly increasing and the majority of the U.S. population, across generations, are willing to use it. The promises are particularly significant for low-income and underserved populations who lack access to health care. As federal and state governments enact and implement Medicaid laws and policies on telehealth, they should keep these principles in mind. Infrastructure and software investments, and increased public awareness will be key to making telehealth use widespread. The principles described above provide some guidance regarding the steps that should be taken when considering policies that will improve access to telehealth services.

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ENDNOTES

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- ² See Am. Med. Ass'n, *Issue Brief: Telehealth: Helping Hospitals Deliver Cost-Effective Care* (Apr. 22, 2016), <https://www.aha.org/system/files/content/16/16telehealthissuebrief.pdf>.
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- ⁹ Gynuity Health Projects, *Telabortion*, <https://telabortion.org/>.
- ¹⁰ See Julia Ries *supra* note 3.
- ¹¹ Am. C. of Obstetricians & Gynecologists, *Implementing Telehealth in Practice*, Committee Opinion 798 (Feb. 2020), <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/02/implementing-telehealth-in-practice>.
- ¹² Children's Hosp. Ass'n, *Success Stories*, <https://www.childrenshospitals.org/Care/Success-Stories>.
- ¹³ See American Well, *Telehealth Index: 2019 Consumer Survey*, <https://static.americanwell.com/app/uploads/2019/07/American-Well-Telehealth-Index-2019-Consumer-Survey-eBook2.pdf>. How consumers want to use telehealth varies greatly by age. Millennials want telehealth to address growing mental healthcare issues. Older populations want telehealth for prescription renewals, chronic care management. Middle-aged consumers are most willing to use telehealth for urgent care.
- ¹⁴ See Am. Well, *Consumers want telehealth—what does that mean for health systems?* (Jan. 23, 2017), <https://www.healthcareitnews.com/sponsored-content/consumers-want-telehealth-what-does-mean-health-systems>.
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²⁶ See Medicaid & CHIP Payment & Access Commission, *supra* note 20.

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