(Updated)Medicaid Principles on Telehealth

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A. Introduction - Understanding Telehealth

While some form of telehealth has existed for decades, exposure to and acceptance of telehealth as a viable option for health care delivery emerged during the COVID-19 pandemic when many patients and providers began to use telehealth extensively for the first time. 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 COVID-19 pandemic also shined a spotlight on the significant health care gaps still existing in the United States. While what is needed is a complete overhaul of our health care system, we can still consider ways to address health care inequities by improving and implementing Medicaid services as well as by utilizing tools like telehealth. To be clear, telehealth is not the ultimate solution for our health care crisis. Telehealth should neither replace in-person care, particularly when that is the best and desired way to attend to a person's health care needs. Rather, telehealth should be considered as part of a long-term, complementary, and sustained strategy to address problems regarding access and convenience for the consumer.

B. The Telehealth Promise

The COVID-19 pandemic highlighted the importance of telehealth in delivering critical health care when patients were not able to receive services in person. States worked to ensure that their residents, including Medicaid enrollees, had access to the services they needed during that critical time. A recent study evaluating the use of telehealth before and during the COVID-19 pandemic found that only 5.3% of primary care physicians used telehealth "often" before the COVID-19 pandemic, while nearly half (46.2%) reported using telehealth often during the

COVID-19 pandemic.[1] Recent studies have also shown that under certain circumstances the quality of services delivered via telehealth was not different from the quality of services provided in person.[2] For example, in a study of patients who participated in a telehealth appointment with a gastroenterology provider, most believed they received a similar quality of care through telehealth compared with in-person visits.[3] Furthermore, most of the patients in the study expressed a willingness to continue using telehealth because of ease of scheduling, increased flexibility, and shorter wait and/or travel times.

In the realm of reproductive and sexual health care, where privacy, timeliness, convenience, and discretion are paramount, telehealth has provided greater access to care.[4] Numerous reports have shown that telehealth medication abortions (TMAB) are extremely safe and effective, regardless of whether the care is delivered synchronously or asynchronously.[5] In fact, TMAB service delivery has expanded dramatically over the last several years, now

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[1] *See* Timothy Callahan et al., *The Changing Nature of Telehealth Use by Primary Care Physicians in the United States*, J. PRIM CARE COMMUNITY HEALTH (July 6, 2022), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9274427/.

[2] *See*, *e.g.,* Derek J. Baughman et al., *Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System*, 5 JAMA NETWORK OPEN e2233267 (2022).

[3] *See* Avi Dobrusin et al., *Patients With Gastrointestinal Conditions Consider Telehealth Equivalent to In-Person Care*, 164 GASTROENTEROLOGY 156 (2023).

[4] *See* Courtney Kerestes et al., *Person-centered, high-quality care from a distance: A qualitative study of patient experiences of TelAbortion, a model for direct-to-patient medication abortion by mail in the United States*, 54 PERSPECT. SEX. REPROD. HEALTH 4 (2022), 177-187.https://www.sciencedirect.com/science/article/pii/S104938671830598X.

[5] *See* Leah Koenig et al., *Patient Acceptability of Asynchronous vs Synchronous Telehealth Abortion Care: A Cohort Study of Telehealth Abortion Care Provided by Virtual Clinics in the United States,* 121 CONTRACEPTION (2023), https://www.sciencedirect.com/science/article/abs/pii/S001078242300080X; Ushma Upadhyay et al., *Outcomes and Safety of History-Based Screening for Medication Abortion: A Retrospective Multicenter Cohort Study*, 182 JAMA INT. MED. 5 (2022), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2790319; Ushma Upadhyay et al., *Safety and Efficacy of Telehealth Medication Abortions in the US During the COVID-19 Pandemic*, 4 JAMA NETWORK OPEN 8 (2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2783451?utm_source=For_The_Media&utm_medium=referral&utm_campaign=ftm_links&utm_term=082421; Courtney Kerestes et al., *Provision of Medication Abortion in Hawai'i During COVID-19: Practical Experience with Multiple Care Delivery Models*, 104 CONTRACEPTION 1 (2021), https://www.contraceptionjournal.org/article/S0010-7824(21)00097-4/fulltext; Elizabeth Raymond et al.,*TelAbortion: evaluation of a direct to patient telemedicine abortion service in the United States*, 100 CONTRACEPTION 3 (2019), 173-177.

accounting for roughly one fifth of all abortions in the United States.[6] Delivery of abortion services via telehealth has become even more important, as it can reduce the ever increasing travel and resource barriers facing abortion seekers after the Supreme Court's decision in *Dobbs v. Jackson Women's Health Organization*. Expanded use of TMAB has many benefits, including addressing access gaps for underserved communities, reducing delays and improving timely access to early abortion care.[7] Further, during COVID-19, telehealth services for adolescent sexual and reproductive health were widely and rapidly implemented in an effort to maintain continuity and minimize disruptions to routine reproductive care. These services were generally well received by both clinicians and patients.[8]

Telehealth can also facilitate care for people with disabilities by reducing the need to coordinate transportation to in-person appointments, increase access to specialty providers, lessen the need to coordinate caregiver support to attend appointments, and reduce the potential for negative experience in public spaces.[9] During the COVID-19 pandemic, 39% of people with disabilities used telehealth. However, a person's type of disability influenced the likelihood they may use telehealth services, with people with mobility disabilities being more likely to use telehealth than people with hearing disabilities.[10] A survey of deaf participants found that 75% of respondents used telehealth over the course of a year, but 65% of those

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[6] *See* Soc'y of Family Planning, *#WeCount Report April 2022 to December 2023* (2024), https://doi.org/10.46621/970371hxrbsk; Leah Koenig et al., *Virtual clinic telehealth abortion services in the United States one year after Dobbs: A landscape review*, J. MED INTERNET RES. (2024), https://www.jmir.org/2024/1/e50749/.

[7] Cat Duffy, Nat'l Health Law Program, *Report: Progress and Gaps in Medicaid Coverage of Telehealth Medication Abortion Services* (2022), https://healthlaw.org/resource/report-progress-and-gaps-in-medicaid-coverage-of-telehealth-medication-abortion-services-in-six-states/.

[8] Amanda E. Bryson et al., *Sexual and Reproductive Health*, TELEMEDICINE FOR ADOLESCENT AND YOUNG ADULT HEALTH CARE: A CASE-BASED GUIDE 85 (Yolanda N. Evans, Sarah A. Golub, & Gina M. Sequeira eds., 2024), https://doi.org/10.1007/978-3-031-55760-6_7 (last visited Aug. 22, 2024).

[9] Natalie Lawson, et al., *Disability and Telehealth since the COVID-19 Pandemic: Barriers, Opportunities, and Policy Implications*, CENTER FOR HEALTHCARE RESEARCH AND TRANSFORMATION (2022), https://disabilityhealth.medicine.umich.edu/sites/default/files/downloads/RRTC%20Telehealth_final2.pdf.

[10] Carli Friedman & Laura VanPuymbrouck, *Telehealth Use By Persons with Disabilities During the COVID-19 Pandemic*, 13 INT. J. TELEREHABILITATION e6402 (2021), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9098125/.

participants reported connectivity issues.[11] Other users reported being connected with interpreters lacking specialized health care interpretation certifications, and some participants needing to resort to their residual hearing to communicate with providers.[12] In order to maximize the potential benefits of telehealth for people with disabilities, telehealth modalities must have the necessary adaptive modifications for anticipated users.

Before the COVID-19 pandemic, polls indicated that 50 million U.S. residents would switch their family practice providers to have access to video visits.[13] In the years following the height of the pandemic, opinion polls demonstrate that willingness to use telehealth services remains high across generations, although those over age 55 are somewhat less willing to use telehealth than those younger than 55.[14] Of those who were recently surveyed, 64.5% expressed a desire to use telehealth and that willingness increased depending on if respondents have an existing relationship with their provider, have long travel distances to their providers, or if the telehealth service was low cost, covered by insurance, or easy to use.

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

As the COVID-19 pandemic demonstrated, Medicaid-eligible and other underserved individuals benefit from telehealth's promises. Before the COVID-pandemic, all 50 states and the District of Columbia provided reimbursement for some form of live video visits in Medicaid Fee-For-Service.[15] 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 aggressively increased telehealth coverage in Medicaid. Thanks to CMS

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[11] Ashley Mussallem et al., *Making Virtual Health Care Accessible to the Deaf Community: Findings from the Telehealth Survey*, 30 J. TELEMEDICINE TELECARE 574 (2024), https://doi.org/10.1177/1357633X221074863.

[12] *Id.*

[13] *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.

[14] Olufeyisayo O. Odebunmi et al., *Findings From a National Survey of Older US Adults on Patient Willingness to Use Telehealth Services: Cross-Sectional Survey*, 26 J. MED. INTERNET RES. e50205 (2024).

[15] *See* Ctr. for Connected Health Pol'y, *CCHP's comprehensive assessment and compendium of state Medicaid telehealth policies and laws covers all fifty states and the District of Columbia*, https://www.cchpca.org/resources/state-telehealth-laws-and-reimbursement-policies-report-fall-2023-2/.

guidance, states expanded and standardized Medicaid reimbursement.[16] These measures—revised in 2021 and again in 2024—will contribute to its utilization and benefit the Medicaid population in the long run.[17]

Much was written pre-pandemic about Medicaid and the advantage telehealth presents for plans' return-of-investment, but little existed then about the impact on consumers. The expansion of telehealth services during the pandemic opened up opportunities to do such research. One such study examined the expanded use of telehealth by patients diagnosed with cancer. The study found that telehealth use was higher among Medicaid cancer patients living in states with more generous payment parity and less restrictive rules for cross-state practice.[18] Privately insured cancer patients living in states with coverage-only parity or no or unspecified parity had lower telehealth use.

Other studies examined the way COVID-19 impacted usage of behavioral health services by Medicaid enrollees. The results indicated that telehealth behavioral health appointments increased dramatically while the overall utilization of behavioral health services, mental health medication, and counseling declined among all racial groups due to the reduction of in-person behavioral health appointments.[19] The increase in telehealth behavioral health services was more likely to be experienced by Latine patients than White patients, while Black patients were less likely to receive telehealth substance use disorder treatments than their White counterparts. Similar results were found in a comparative study on behavioral health service use of a cohort before and during the pandemic. Two-thirds of the cohort received behavioral health services during the pandemic with about half of those received services via telehealth. Those who did not utilize telehealth during the pandemic saw greater declines in services use pre- to during the pandemic than telehealth users.[20] A fourth study looked at the telehealth usage of Medicaid patients and rural residents managing hypertension post-pandemic. The

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[16] CMS, *State Medicaid & CHIP Telehealth Toolkit: Policy Consideration for States Expanding Use of Telehealth* (COVID-19 Version), https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf.
[17] CMS, *State Medicaid & CHIP Telehealth Toolkit: Policy Consideration for States Expanding Use of Telehealth* (February 2024 Version), https://www.medicaid.gov/media/171426.
[18] Tina W F Yen, I-Wen Pan & Ya-Chen Tina Shih, *Impact of State Telehealth Policies on Telehealth Use among Patients with Newly Diagnosed Cancer*, 7 JNCI CANCER SPECTRUM pkad072 (2023), https://doi.org/10.1093/jncics/pkad072.
[19] Winnie Chi et al., *Impact of COVID-19 on Behavioral Health Services Use Among Medicaid Enrollees with Chronic Behavioral Needs by Race and Ethnicity*, 26 POPULATION HEALTH MANAGEMENT 325 (2023), https://doi.org/10.1089/pop.2023.0077.
[20] Alexis French et al., *Telehealth Utilization Among Adult Medicaid Beneficiaries in North Carolina with Behavioral Health Conditions During the COVID-19 Pandemic*, J. RACIAL AND ETHNIC HEALTH DISPARITIES (2023), https://doi.org/10.1007/s40615-023-01730-2.

results indicated that rural patients and Medicaid patients saw higher telehealth usage than their more urban and non-Medicaid counterparts without any drop off in their ability to manage their hypertension.[21] Such results indicate that telehealth can expand access to health care services for the Medicaid population without compromising chronic condition management, given that the access needs of traditionally underserved groups are centered in the adoption of telehealth policies.

D. Medicaid Principles on Telehealth

Because telehealth laws vary so much from state to state, developing a set of baseline rules and principles for its use is important. They are the following:

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 belief, language proficiency, and geographic location. At a minimum, telehealth services must comply with all existing civil rights laws, including but not limited to, 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. In May of 2024, the HHS Office of Civil Rights (OCR) issued a new final rule on Section 1557 of the Affordable Care Act confirming that delivery of health programs and activities through telehealth must not discriminate on the basis of race, color, origin, sex, age, or disability.[22]

Unless deemed necessary by the telehealth provider, telehealth interactions should not require patients to 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.

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[21] *See* Matthew Mackwood et al., *Telehealth Trends and Hypertension Management Among Rural and Medicaid Patients After COVID-19*, 30 TELEMEDICINE & E-HEALTH e1677 (2024).
[22] Nondiscrimination in Health Programs and Activities, Federal Register (2024), https://www.federalregister.gov/documents/2024/05/06/2024-08711/nondiscrimination-in-health-programs-and-activities (last visited June 21, 2024).

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.[23]

The use of telehealth should not derail network adequacy and other managed care protections.[24] 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-service 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 services, 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.

[23] The Patient Protection and Affordable Care Act, Pub. L. No. 111-148 (March 23, 2010) and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 (March 30, 2010) (collectively the "Affordable Care Act (ACA)") §2719A.
[24] 42 C.F.R. § 438.68(c)(1)(ix).

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 and their staff 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 and authorized by the patient so that patients know and approve if, when, and how their medical records are transferred from one provider to the other. It is absolutely critical that patients have complete control of their medical records, especially if they want to keep them private from certain providers and third parties.

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 health care 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 fee-for-service 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 provider capable of offering services via telehealth.

A patient-provider relationship can be established via telehealth; therefore, an in-person interaction should not be required to receive Medicaid reimbursement if the service can be provided via telehealth and patients and providers alike agree to a telehealth encounter.

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. 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, Indian 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. Research on telehealth for children with medical complexity revealed that care coordination reduces unplanned health care visits and increases attendance at planned visits, particularly for post-hospitalization telehealth visits.[25] A similar study is underway that will assess the effectiveness of a multidisciplinary telehealth hospital discharge intervention for children with medical complexities.[26] The goal of the study is to determine if the telehealth discharge intervention can lower 30-day post-discharge urgent health care reutilization.

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

The patient can be located in any originating site, including, but not exclusively, the home, school, community health center, homeless shelter, etc. 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. Congress should reauthorize funding for the Affordable Connectivity Program, which provided eligible households a monthly discount for broadband internet service and a one-time discount for purchasing needed equipment such as smartphones or tablets (as well as data plans or internet access) to support telehealth visits.[27]

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[25] *See* Ruchi Kaushik, *Telehealth and Children with Medical Complexity*, 53 PEDIATRIC ANNALS e74 (2024).
[26] *See* Amanda Warniment et al., *Garnering Effective Telehealth to Help Optimize Multidisciplinary Team Engagement (GET2HOME) for Children with Medical Complexity: Protocol for a Pragmatic Randomized Control Trial*, 18 J. HOSPITAL MED. 877 (2023).
[27] FCC, Affordable Connectivity Program Has Ended for Now, https://www.fcc.gov/acp (last visited Sept. 24, 2024).

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

Even when telehealth services are available, people might not know how, when, and where to use it. 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, navigators, and communities. Enhancing consumer education in underserved communities could significantly increase telehealth use and overall access to health care services. Providers and their staff should be continuously educated on the advantages and technologies that facilitate telehealth – keeping 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 of the patient's health care. Medicaid should offer reimbursement for all modalities, including:

- Live Video (Synchronous): Live, two-way interaction between a person and a provider using audiovisual telecommunications technology.
- Store-and-forward (Asynchronous): This involves a combination of dynamic intake forms, direct messaging, and secure HIPAA compliant applications to transfer pictures, medical history, consent forms, and other patient information or questions to facilitate non-live interactions between a patient and a provider. 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.
- 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.

- Audio-Only and other 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 Latines are more likely to access the internet through mobile devices.[28]

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, including in 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.

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. The rise of telehealth use during the COVID-19 pandemic offered such opportunity. In particular, additional research on the impact of telehealth on access for low-income consumers and their health outcomes is becoming more common. For example, a recent study showed that telehealth was effective at helping vulnerable patients who visit Community Health Centers with diabetes stay connected to their care team and involved in care.[29]

[28] *See* Yohualli Balderas-Medina Anaya et al., *Meeting Them Where They Are on the Web: Addressing Structural Barriers for Latinos in Telehealth Care*, 28 J. AM MED INFORM ASSOC 2301 (2021).
[29] Jodi Simon et al., *The Role of Telehealth in Improving Care Connections and Outcomes for Community Health Center Patients with Diabetes*, 37 J. AM BOARD FAM MED 206 (2024).

E. Conclusion

Telehealth can help Medicaid eligible populations gain better access to providers, while safeguarding their privacy and offering a more convenient option to access health care. While telehealth is not a panacea, it should be considered as another tool that supports access to health care. The promises are particularly significant for low-income and underserved communities. 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.

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