REALTIME FILE

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TELEHEALTH POLICY UPDATE, CHANGES FOR 2021
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Murlean Tucker: welcome to telehealth policy update, changes for 2021. this is the eighth in an eight part series on telehealth innovation in the era of COVID 19, lessons from the field, my name is Murlean Tucker and I will be running this dialog for health web form. Thank you for a partner's for today's event, UC Davis health, transatlantic health research network , citrus and the Institute, the international Society for telemedicine and E health and the Gary and Mary West foundation.

Now it is my pleasure to introduce Dr. David Lindeman, the moderator of this event. Dr. Lindeman is the director of health for the information technology research in the interest of society at UC Berkeley and the director of the Center for technology in aging, welcome back to the mic, David.

David: thank you Murlean. And thank you to all of you in attendance both in the US and across the globe we appreciate having you here for us on this webinar a very important one for telehealth policy particularly in light of the changes that this audience knows all too well that have occurred because of the Covid 19 pandemic. We are seeing amazing innovation in telehealth over the last eight months. We have seen expanded adoption over the entire year. Telehealth has increased healthcare access to those around the world especially in remote communities not only dealing with transportation issues, but the specific issues that have been brought to light through the pandemic.

Due to the pandemic we have also seen major changes in policy in each country particularly here in the United States, which is what we will address today. We will talk about new changes related to waivers, new regulations, new payment models and the different ways that telehealth has been changed to improve access to tremendously increase the number of individuals who, and the providers who have now turned and fully embraced this area.

While we have had temporary policies to date , many in Medicare, Medicaid and the US, we are beginning to see the issues that are going to come in terms of final, different types of policies that will be required to change to stay to help confirm that telehealth will be maintained into the future. The evolving challenges of providing remote care to vulnerable populations is a global challenge and requires requires changes in care practice innovations in use of tech advances in communications and rapid change in reimbursement regulatory and workforce processes. This webinar will address a number of these issues and look at the ways we will need policies to help support not only the transitions in telehealth, but making sure that we maximize telehealth in the years to come. Is my pleasure to introduce you to our three speakers we have today with us Mei Kwong who is the executive director at the Center for connective health policy and has been a leader in this space and the national expert in policy issues related to telehealth at both the state and federal level. She is the project director for the national telehealth policy resource Center for the US. In addition we will be joined by Julie Bates. Julie is the associate state director for AARP California and has been a leader in telehealth issues for older adults particularly with the California telehealth policy coalition where she not only represents AARP but has been the chair of the subcommittee on education regulation, and also addresses legislative issues. And finally we will, we are pleased very much to have Trong Le, who is assistant director policy at the California primary care Association where he has been specializing in work not only related to Medicaid plan throughout the United States but Medicare issues and, again is monitoring federal and state legislation throughout the US. So it is my pleasure to open the program and make the initial introduction to Mei Kwong, who will start us on the first program session. Mei, the floor is yours.

Mei: thank you David and thank you everyone for having me here today as David mentioned my name is Mei Kwong I'm the executive director at the Center for connective health policy. Before I start I have to give a disclaimer that any information today is not to be regarded as legal advice and it's straggly for informational purposes. CCHP always recommends you consult with legal counsel if you need help on opinion, and if I mention any product please know that I nor CCHP has any financial interest arrangement or financial arrangement with such a company so CC HP was established in 2009 under the Public health Institute. We were actually established as a California telehealth policy organization but an opportunity to become national telehealth policy research Center became available in 2012 through a grant from percept. We have applied for that and served in the capacity ever since but also work for a Friday of other funders and partners on more specific telehealth or public health projects.

Other projects we do, we do a 50 state report on the state telehealth Medicaid policies laws and regulations. We are also the administrator of the national organization telehealth research center and we can be in the California telehealth policy coalition which as you heard Julie was the education subcommittee chair and also Trong is the incoming vice chair for the legislative subcommittee. The national contortion of telehealth resource centers is made up of 14 telehealth resource centers under the

same grant program CCHP there are two national centers. CCHP is one policy and there is one on technology and there are other centers that cover specific states. I like to call it sort of your frontline for telehealth questions. If you have a question about how to start a program how to set up policy or technology reach out to the hell health resource Center and they will be able to answer the questions for those in the US. Some of the telehealth resource centers to have a bit more of a global reach. So if you are an international member or person they may be able to assist you with that but they are primarily focused on US telehealth issues.

I mentioned our 50 state report. This is just a snapshot of our website. It isan interactive map. We keep that updated to make to further major updates every year but more recently we've been updating the online version on a more frequent basis. So if you download the PDF it is updated through October 2020 but if you go to the website you can see it's updated on a more frequent basis. So in the US before Covid 19 at least federal policies on telehealth were very limited. A lot of it is centered around Medicare and what Medicare would cover and reimbursement. There were other types of policies that impacted telehealth utilization such as how you would prescribe a controlled substance. But on the federal level there were a lot of the policies were really centered on what Medicare would do or allow for telehealth.

Covid 19 hits, and that really scrambles what happens with telehealth. It really elevated telehealth in a way that we had not really seen before. I have been doing this for about 10 years and at least on the temporary side of things for policy, it really shot forward in reaction to Covid which makes sense again just given the nature of the pandemic it makes sense to utilize telehealth as people were isolating and trying to limit contact but still needing to receive healthcare services.

This is a very high level overview of the telehealth policy changes in response to Covid both on the federal and state level. And when you're talking about US telehealth policies you do need to separate it out and look at it both from a federal lens and a state lens.

So on the federal lens I mentioned a lot of it is centered around Medicare and changes that were made there.On the state level you are looking also not only on the Medicaid program but also on what private payers or commercial payers do with telehealth as well. As far as the topics or the areas in which there were changes made in response to Covid you will see there's actually like very common types of areas that both the federal and state made changes and that is because a lot of the established policies of both federal and state level have to do with what is covered. What you get paid for if you use telehealth. So those reimbursement policies have some basic elements. That is why you see the issues pop up both on federal and state level. And if you want to go into more detail I think probably most of the attendees here are familiar with some of the changes that have happened. You can go to the CCHP I This is a snapshot of some of the impact of the policy changes and I want to stress these are temporary changes mostly on the federal and state level these have been temporary changes. Some have been made more permanent or changes have been made --- but for the most part this

has been temporary. For the most part there are telehealth policy ranges that have been made as no surprise you see there's a spike in telehealth utilization in the early months of Covid and then it kind of peters down because that's were more places were opening up and stay-at-home orders were lifted and people were feeling more comfortable going back to clinics and hospitals.

But then as cases started to rise again you see the utilization of telehealth also rise. In the early months of Covid, policy was moving very rapidly and like the changes that were occurring. And then there were a couple of months where it sort of stabilized essentially like they have done enough policies and they have done what they needed to do in order for telehealth to be used. However we have seen in the last couple of weeks it started to pick up again and the reason I'm going over that is we have here a list of proposed fee schedules because when I turned in my slides for this presentation that was accurate but that is inaccurate right now. So it is no longer a proposed position fee schedule for 2021. It's a finalized position fee schedule so now we are seeing in December a little bit more movement again what is going on with telehealth policies changes that are happening now and maybe some of them are being made permanent. But the information there just take out the word proposed and put in finalized and that actually makes it accurate.

What we are starting to see is as David mentioned, some of these temporary policies are starting to be made permanent.

Now what is being made permanent at least through the federal level and Medicareis through something called the proposed position fee schedule. For those who are not familiar with that, that is a set of recommendations that Medicare or CMS usually makes usually in the summer of like what they are going to be doing for the following year, what they are going to cover. What are they going to change. This year, they have done, they have taken some of those temporarily allowed services that they said can be provided during telehealth throughout the pandemic and put them on the permanent telehealth list. That is the only thing that they really did as far as the major changes that have been made. Temporarily in response to Covid mainly because that is the only sort of area in which CMS can act administratively.

So for the major changes underneath Medicare such as removing the limitations on where telehealth could take place and the type of providers that can provide those services CMS cannot act unilaterally. Those policies are enacted in federal law so they need permission or Congress to change the law in order to act and so they need to act temporarily in response to Covid but to make a permanent change CMS cannot do anything.

The one area where they can make changes and do it administratively is what services they may cover and that's what they've done with the fee schedule. They have done a couple other things but that has served as the major portion of making things permanent they are allowing certain services to be on the permanent list of telehealth

reimbursement. So when the public health emergency is over the sort of handful, it is about 15 different services or different codes, will be on the permanent list and can still continue to be provided via telehealth and the provider will get reimbursed.

There were a couple other changes that they made that again were temporary changesand that were within the scope to do. And those were such things as like frequency of visits. The nursing home before Covid 19, if they were only allowed to provide nursing home visits via telehealth once every 30 days. They took out that frequency limit temporarily during Covid and they decide to make a policy change to allow for a visit at least once every 14 days. And so there are these like smaller changes that have been made. Mainly because they have CMS themselves cannot do much without Congress acting.

Without Congress acting that is what is on the horizon as far as making these changes permanent via Congress and so we have got a series of bills and this is just a sampling of the bills to try to make portions of the telehealth temporary changes permanent on the federal level. I will be honest with you, I don't think any of these bills will pass for various reasons. I think what is more likely to happen is that some elements of these bills will be put into larger bills. And so for example if another Covid bill were to be introduced and be voted on you may see some of these telehealth changes permanent changes put into the larger bill. And that is giving sort of historically what they have done with federal telehealth policy changes. I don't think any of the telehealth bills themselves have a chance of passing. Most likely we will see them included in a larger bill.

What are the states doing? state Medicaid reimbursement before Covid 19, it was actually a little bit all over the place. At least in the Medicaid program you had live video being reimbursed for something in every Medicaid program. Store and forward and patient monitoring were not as popular. States also have private payer laws and what the laws do are telling commercial payers what they need to do as far as telehealth is concerned and again these were all over the place. You had the two extremes of state telling commercial payers that they can't cover telehealth if they want to a state that maybe will say they have to cover telehealth delivered services the same way they would have in person and they would also have to pay the same amount. And other states just following in their somewhere between those two endpoints.

We have seen in permanent state telehealth changes we looked at it from July to August 2020 and saw 31 states had made permanent telehealth policy changes a lot was done to administer to channels in the Medicaid program. We are also not sure if none of them were done in response to Covid. Obviously if they mention Covid that was done in response to Covid, but some of the policy changes were just policy changes and we were not sure if they were perhaps something they were thinking of doing before the pandemic hit. As far as Medicaid changes what we were seeing were very specific type of changes, not sweeping changes such as there might be adoption to Telefon reimbursement of Medicaid but only for a narrow set of services. A lot of

clarified policies things things such as yes the home can be an emergency site or yes FQ HC's can provide services via telehealth in the Medicaid program. And this is just another couple telehealth Medicaid policies on telephone specifically. As far as legislation, if you are comparing 2019 to 2020 you see sort of the areas of legislation and the type of topics shifted slightly. A lot more interest in like Medicaid reimbursement. Then you will see also licensure was likely more popular last year than it was in response to Covid but regulatory and licensing types of of legislation was definitely about again less popular in 2020 than in 2019 but private payer reimbursement is definitely something of interest during the past legislative session.

So there were 104 legislative bills in 36 states that past. Again, these were the sort of more popular areas and 35 of the bills were directly in response or explicitly mentioned Covid. Medicaid there were some of these I think you guys get copy of the slides some going to go through these really quickly. What is going on though in California, California actually was in a better position than a lot of states going into Covid. The Medicaid program had actually just updated their telehealth policies and made them pretty expensive so there were areas in which the policies were still lacking in allowing telehealth to be used to its fullest capacity. And made changes to the pandemic and I think Trong is going to go over these and more details but this is changes that had to be made in California in response to Covid.

Where does California stand? We are still in a state of only having these as temporary policies right now. Nothing has been made permanent. This last legislative session there were two bills that had passed that would have helped and made it to the governor's desk but they were vetoed. Governor Newsom and his veto message to say the department of healthcare services was evaluating its global telehealth policies. He has mentioned telehealth a few times in different respects. And it was vital to the recovery of the state and once I got past the pandemic so we are in sort of a wait and see pattern of what is going to happen to the state itself on telehealth policies and hopefully some of these things will stick around as we go into 2021 and into future years. I'm going to stop there and I think Julie and Trong will go into more detail on things. These are some links to our website and resources and I just thank you.

David: thank you very much Mei. And again we know again there is so much behind that and we are appreciated you sharing that overview in providing links to the centers work on that and I do think it sets the tone for so much that is still in process at this point. And still to be determined and as we get into the Q&A session I think we want to ask questions of all of you regarding advocacy and how do we determine how these decisions can be influenced and finally how quickly they may come online. And so now we will turn to Julie Bates, again, associate state director for AARP who will be speaking to specific issues related to populations for older adults. Julie the floor is yours.

Julie: thank you, David. Let's see. There we go. It is an honor to be here this morning. And to present to the assembled group. AARP California has a long-standing relationship with David Lindeman including his being a volunteer with the voluntary

executive Council of AARP and he also introduced AARP for the Center for connective policy over six years ago and at the time the executive director, the late Mario Gutierrez who invited AARP to join the California telehealth coalition we were the first organization representing consumers to join the coalition and specifically representing people 50 and older and their families.

This morning I will cover the impact of telehealth expansion at the national and state level. There are opportunities for spinning telehealth for all Californians and beyond. And as Californians age--- Californians will play a critical role in the state and nation recovery and growth even after accounting for the impact of Covid 19 California's aging population will continue to make economic and social populations that benefit people of all ages. And the growth of this age group will fuel innovation and new market solutions policymakers, business makers and elected officials must ensure programs and policies are in place to support and grow this economic action. They need to focus on the older population not just because they will need healthcare and telehealth options but because Californians and the nations 50+ population creates outsides economic impact and will drive economic growth for the next 30 years. In 2018 to 50+ population accounted for 33% of California's population yet contributed 37% or $1.062 billion of the state's gross domestic product. The activities are supported, their activities have also supported 9.8 million jobs and have generated $733 billion in wages and salaries. The 50+ cohort provides caregiving for children and adults. The 50+ population in California contributed $68 billion in unpaid caregiving in 2018 and the average person spending $40 $3800 in caregiving over the entire year. It is important to have contacts and understanding about the impact of the 50+ population California. And beyond.

Now, I am here because of AARP and I think it is important to give you some understanding about who AARP is and why we are at the table. So this woman that you are seeing here is Dr. Ethel Percy Andrus. She founded AARP back in 1958. And this organization has grown to be 38 million members nationally with 3.3 million. In California alone. It is the largest nonprofit organization dedicated to empowering Americans 50 and older to choose how they live as they age. AARP's founder Dr. Ethel Percy Andrus was many things to many people, I teacher, patriot, mentor , a leader of visionary, a trendsetter, a disruptor and advocate and innovator and voice for older adults struggling to get by.

More than anything, she was a catalyst our founder believed deeply in the power of individuals to improve their own lives and to lead social change making life better for others. Dr. Andrus was the first meal principle in California serving at Lincoln high school in the Los Angeles area. AARP was founded on the simple premise that no one should have to live in the chicken coop, the shocking discovery of a distinguished former teacher living in poverty inspired our founder to develop the rest of her years improving the quality of life for all as they age. AARP works to strengthen communities and advocate for what matters most of families with a focus on health security, financial

stability and personal fulfillment. AARP also works for individuals in the marketplace by sparking new solutions and allowing carefully crafted products to come to the forefront.

AARP represents the needs of nearly 38 million members with lifestyles and political views as diverse as any group in the US. Developing public policy... It is still early in California... Developing public policy recommendations that serve such diversity is a formidable task. We concentrate on issues most important to those in the 50+ community as they age. Economic security, healthcare, access to affordable quality long-term care, meaning maintaining livable communities consumer protections caregiving and ensuring that our democracy works better for all. AARP policies consistent with our mission to empower people to choose how they live as they age , guide the organization's advocacy and support for specific bills and regulations at the national, state and local levels. We do not take a position on bills that are not in our policy book. You can learn more about our policies by going to the link on the slide, AARP.org 4/policy book.

Covid 19 has ushered in the era of telemedicineand older Americans have embraced the change in record numbers at that at least was the result of the poll taken in July by AARP and sponsored by the health insurance industry. It found that virtual doctor visits skyrocketed by 300% among Medicare eligible seniors since the start of the pandemic. And nearly half of the surveys were comfortable with using telemedicine in the future. And avoid in-person medical payments while the coronavirus --- might improve a practice that continues pandemic or not. Covid 19 has led to change in all facets of life within the US healthcare system one of the most substantial ships has been the rapid expansion of telehealth services. These changes are likely to remain long after the Covid 19 pandemic subsides given that the Covid 19 pandemic will persist long into 2021 older individuals remain at higher risk of its harmful effects, telehealth utilization is expected to continue to increase and become a standard part of healthcare services for older adults. AARP has been actively engaged in telehealth since Dr. Lindeman brought this to our attention more than five years ago and it is an issue on our national dashboard.

For people with modality issues and mobility issues telehealth apartments can save at least one trip or treatment step especially in the area of virtual urgent care for the relatively minor aches and pains that normally prompt us to see family physicians. When you have a earache, sore throat, urinary tract infection, sometimes, or other signs and symptoms of infection, but you do not think you have Covid 19 and you do not think you're sick enough to be hospitalized a video visit with your primary care doctor may suffice. And from home the doctor may actually be able to see, and you have all of the pills that you're taking right in front of you when you're physician asks about them telehealth seems to work well in the management of chronic diseases. Diabetes heart failure and other ailments that require regular management and follow-up care, providing convenience to those burdened by the need for an appointment after appointment after appointment. What is more what's more evidence shows the quality of

care is the same. Evidence even suggest that shifting more hospital recoveries to the home with help of telemedicine is beneficial to those with chronic conditions such as heart failure, COPD and emphysema.

What can and cannot be done in a telehealth visit with my healthcare provider is often a question that we hear. We now know that you can be diagnosed advice and treatment or therapy. You can do it at home. You can monitor a wide range of conditions or symptoms. Telehealth visits can be used to address urgent care needs just a Mexican or sinus infections, or to manage chronic conditions as mentioned before and in response to the coronavirus outbreak the US drug enforcement administration issued clarification on healthcare professionals to subscribe controlled substances through Tele health medicine as well providers previously were required by law to meet the patient at least once a person before doing so. --- nor is telehealth a substitute for calling on one or visioning the emergency in the event of life-threatening condition such as loss of consciousness or broken bones. But telehealth can definitely be an integral part of your healthcare delivery model.

Now one of the questions that we often hear is how much does it cost to do a telehealth visit. And of course our perspective is that of the 50+ population and as with in person Dr. visit the cost of telehealth services varies. Based on a variety of factors such as insurance factors the time and length of your visit. A 2017 study published by the Journal of health affairs found that on average a Tele visit cost about $79 compared with $146 for an office visit. And ultimately will Medicare pay for my visit? Medicare has temporarily expanded coverage of telehealth services in response to the outbreak allowing us to beneficiaries of original Medicare to have virtual visits with her doctor on a smart phone or other device and without a co-pay for routine visits mental health counseling and mental health screenings providers are also allowed to waive cashiering for these appointments. Medicare advantage plans make offer additional telehealth benefits.

So it is important to check your coverage because it is not a one size fit all plan or the same from person-to-person plants. There we go. The coronavirus preparedness and report supplemental appropriations act was signed into law which among other things gives the US Department of Health and Human Services HHS the authority to temporarily waive certain requirements for telehealth services.

Patients can look at telehealth services from an expanded group of healthcare professionals including physical and occupational therapists and speech line which pathologists. Under the changes CMS officials say will help ensure the beneficiaries do not have to leave their home and risk exposure to Covid 19 and Medicare has been wrapping up the use of telehealth in recent years but while Medicare advantage plans have been allowed to offer liberal telehealth policies for several years beneficiaries of original Medicare have had more limited telehealth benefits and managed to reach virtual check ins and beneficiaries would not generally be able to get telehealth services in their own homes. About 40 million Americans are enrolled in original Medicare.

From 2019 to 2020 there was a substantial increase in the proportion of older adults who reported that their healthcare provider offered telehealth visits. In May 2019, 14% of older adults said their healthcare providers offered telehealth as it compared to 62% in June 2020. Similarly, the percentage of older adults who had ever participated in a telehealth visit rose sharply from 4%, that's right, 4% in May 2019 to 30% in June 2020. Of those surveyed in 2020, 6% reported having a telehealth visit prior to March 2020 while 26 reported having telehealth visit any period of March to June 2020. Among adults age 50 to 80 who had a telehealth visit and this time from March to June 2020 76% reported that it was with a primary care provider. 32% with a specialty care provider. And 18% with a mental health provider. Respondents said the most recent telehealth visit was conducted via video by phone at 33%. Video by tablet or computer, 31% or by phone with audio only, 36 June 2020 older adult said that video or telehealth were the only option available for an appointment. Nearly half indicated that in person visits were canceled or rescheduled telehealth visits by the health care provider.

Fewer than one in six or 15% reported that fear of Covid 19 led them to request or reschedule an in person appointment as a telehealth visit. And while regular Medicare co-pays will apply to telemedicine visits, CMS officials say that during the coronavirus emergency providers can waive or reduce cost sharing for more telehealth visits. Clinicians on the front lines will now have greater flexibility to safely treat our beneficiaries, and that is important. Even with all of the expansions, barriers remain.

More than 26% of Medicare beneficiaries like digital access at home, according to an August 2020 study by the University of Pittsburgh researchers published in JAMA. This made it difficult for them to have video visits with medical professionals. Perhaps not surprising, the proportion of Medicare enrollees who lacked high-speed Internet connection or smart phone with a wireless data plan which are necessary for digital access was substantially higher among those who are 85 or older, widowed, of lower social economic status or in communities of color. Seniors without digital access would have to rely on audio only visits by phone, which these researchers noted might not be adequate in situations where visual monitoring or diagnosis are critical.

Telehealth does increase access care for patients who otherwise would not get it or who are fearful to go out of their homes or cannot afford, but at the same time we can't ignore the fact that not everyone knows how to use technology, or has a smart phone. We don't want to widen health care disparities. The most common concerns about telehealth visits among older adults surveyed in June 2020 were that healthcare provider cannot conduct a physical exam and that the quality of care is not as good as in person. Other concerns noted, were not feeling personally connected to the healthcare provider or having difficulty hearing or seeing what the healthcare provider was seeing or doing and then of course there was a concern for privacy. Over the past year, some concerns about telehealth visits decreased among older adults aged 50 to 80 whether or not they had a telehealth visit. Older adults concerned about privacy and telehealth visits decreased by more than 49% in May 2019, to 24% in June 2020. And

concerns about having difficulty seeing and hearing a care provider in telehealth visits also decreased from 39% in 2019 to 25% in 2020. Concerns about feeling personally connected to the healthcare provider decreased slightly from 49% to 45%. Showing that when we are able to actually have a telehealth visit our fears and concerns about telehealth visits go down.

In the June 2020 survey those who had telehealth visits were less likely than those who did not have telehealth visits to report concerns about privacy. Part of the solution of course is you can't access telemedicine if you do not have access to high-speed Internet. And so part of the solution is making broadband public utility in much the same way electricity became widely available in the early part of the past century, to increase access to everyone. Universal broadband is one of the ingredients but seniors also need support like a digital concierge.. All of these steps. All of this is more practical to going to see a doctor once or twice a year and that is what is making things so exciting about the expansion of telehealth benefits and access. Again there more issues to overcome and need to be overcome at the state and federal level. We can pass all of the policies to remove barriers to telehealth, but without access to affordable reliable high-speed Internet we will continue to see the digital divide we have today.

In 2017 data from the Public policy Institute of California reveals that 74% of Californians currently have access to broadband at home. This aptly named digital divide persists across various demographics including communities of color, lower income Californians and those without a college degree.

At a time when an increasing number of workers are engaged in telework, students are utilizing remote learning and small businesses are seeking to remain operational through remote delivery or take away sales access to a robust telecommunications and high-speed Internet network is critical. This access also increases opportunities for telehealth allowing patients and providers to meet remotely. Likewise it allows those who live alone as well as residents of nursing homes and assisted living facilities to stay connected to family , friends and medical services. Thus, access to virtual communications options can be essential to one's emotional, mental and physical and social well-being. I have a lot more to say on that. But I want to make sure that Trong has more than enough time so I'm going to move on.

Of course, telehealth during the Covid 19 pandemic. Nursing homes are a hotbed of the virus. Basic precautions to stem the loss of life and residence and staff are not yet in place and others much more than needs to be done here and AARP is in fact responding, fighting to save lives , to ensure that PPE is available in nursing homes and they have access to telehealth at the bedside.

AARP has done an extensive amount of education individuals 50 and over with regard to Covid 19. You can find all that we are doing online afterwards and there is a link to our site shortly.

And so of course AARP California and AARP national wants are federal and state governments to encourage coverage and payment of telehealth services including by removing unnecessary restrictions that limit beneficiary access. For eligible beneficiaries to improve access to quality care and allow patients to remain safely in the community and assist with care transitions. [Indiscernible] covered legislative advocacy and beyond, just know that AARP is working on advocacy and statehouses across country and Washington DC to make permanent the expansions that were made possible because of Covid 19.

And again, if you want to know all of the things and all of the research and all of the stuff that is available to you in regards to AARP's work on Covid 19 education outreach and legislatively you can find it AARP.org\coronavirus. And with that I turn it back to you, David and Trong.

David: thank you Julian thank you for highlighting some of the very underlying issues particularly around broadband and making it universally acceptable as we move forward. You have also identified a number of issues. We have a number of questions already coming up related to the broad set of populations not only older adults but children, different ways to go over telehealth behavioral health, all of the things that Julie just mentioned, the relevance well beyond the older adult population throughout the world.

I would like to quickly turn to our next speaker. We are delighted to have Trong Le. From the California primary care Association to address other policy issues we are seeing and we will mention that if you do have any questions we will have limited time but please do put them in so that our speakers can also get back to you off-line and in the future. Trong, the floor is yours.

Trong: all right thank you David, can you hear me?

David: Yes

Trong: okay so just quickly CPCA is a designated primary care Association by --- that support the health center so in short we represent over 1000 community clinics and health centers in California and if you don't know, community health centers stem from the civil rights movement. And we are located in a different areas across the state to serve those patients who face significant barriers to care such as cost, lack of insurance, distance or [indiscernible].

Since the beginning of the Covid 19 pandemic our vision has always been to ensure the Covid 19 testing , treatment and vaccine distributions are available equitably to all patients especially those who are disproportionately impacted by Covid 19. All right. So I know that Mei has gone over some of this but I just want, so actually folks can understand from the community health center perspective. We currently have certain flexibilities to provide telehealth and those flexibilities did not exist prior to Covid 19.

On the federal side Congress enacted the CARES act that allowed committee health centers to act as a distance I provider during the pandemic and as noted earlier in order for a community health center to maintain that flexibility further federal legislation is needed. And so all of the federal flexibility that we are having right now will expire at the end of the public health emergency declarations.

On the stateside, under state bill AB 1494 that was enacted last year health centers are allowed to provide telehealth and a telephonic care during a pandemic. Also those flexibilities will go away at the end of the public health emergency.

A deeper look into some of those flexibilities I know [indiscernible] I will quickly go over these but I quickly want to emphasize the changes that allow health centers to provide telephonic care. And I will tell you why in a second, but that is huge for health centers, and especially when you heard from Julie about how people even have devices to use telehealth they may not have the broadband access or the Internet necessary to conduct a telehealth visit. Some of the key changes at the federal level that allow health centers to provide telehealth services including allowing them to act as the business side provider and allow health centers to use telehealth to establish [new patients]. Prior to Covid 19 the patient had to first physically come into a clinic in order for the patient and provider relationship to be established and then after that they can use telehealth. That requirement is waived currently during the Covid 19 pandemic. So that is also a very significant change for us.

Now switch over to the stateside. You can see some similar changes mirroring the federal changes. So one is allowing telehealth and telephonic services provided by community health centers. Other changes including waving the four wall requirements. And so prior to Covid 19 health centers and their patient have to be within the physical four walls of a clinic to provide services and bill for the services. Now that requirement is currently waived to allow the patient to be at home or at their work to be anywhere and still access telehealth care. Right, that is instituted by Covid 19, but at the end of the day you can see a substantial benefit of that waiver of requirement allowing patient access care wherever they are. Instead of driving a long distance to a clinic or medical offices for 15 or 20 minutes medical appointment. Some other changes that I kind of want to call out here is the face-to-face requirement, which allow the telephonic services and also the established patient requirements that are currently waived during the pandemic.

Now all of the flexibilities, and we are extremely happy because of the fact that they are needed in light of the current Covid 19 pandemic, but as you see here we look at the utilizations of those services at the beginning of the pandemic we saw a very sharp increase in telehealth understandably because a lot of people try to ramp up telehealth to kind of supplement for the loss in in person visits however as the time goes by the number of telehealth visit slightly dropped and in the data from last month showed us that right now telehealth visits is about 47% among the health centers. And this is understandable right as we can imagine when the in person visit is not available both

patient and provider's try to utilize telehealth as much as they can. As the country and the state, we open at different phases. Both patients and providers are getting a little bit smarter and creative in how to leverage telehealth in conjunction with the in person visit. So you see the uptake and in person visits in combinations of a slight drop of telehealth. And we do expect that change to continue into the future of the telehealth state.

Another question we recently looked at was to understand how the patient responds to telehealth and to ensure the patient can access telehealth services and are comfortable with those various Health Centers conducted patient satisfaction surveys. And I will quickly go over this slide to say that many health centers see comparable if not higher level of patient satisfaction regarding telehealth compared with telehealth and in person visit, which is a key question when we try to advocate for permanent telehealth is whether or not the patient feels comfortable and will understand and like telehealth. Let's go on the next slide. I also want to share a recent report done by the California healthcare foundation's for your reference on this call. It is a study among low income patients across the state. And the result is similar to what individual health centers found in the patient satisfaction survey. That a majority of respondents, when, after they have a telehealth visit they do prefer to have that option moving forward and respond very positively to telehealth and telephonic services. All right.

So these, this slide and the next slide focus on what Julie mentioned earlier about access to technology devices and broadband and patient preference to maintain a telephonic services or access to telephonic services. One of the reasons for that is if you look at the patient population that includes elders includes low incomes patients and includes includes patients who live in rural areas that might not have access to [an LTE network]. Having a cell phone or having a laptop or desktop computer may not allow, may not translate to access to Internet access or access to telehealth visits. So that is something that we do want to look at and we do want to advocate for equitable broadband access here across the state. But this poll, survey that we did with community partners showed that a substantial number of people do not have access to either laptop tablet or desktop so they have to use their phone. They have to use the LTE network in order to access telehealth services. And one of the questions that we also ask is preference and a majority of them show that they do have a preference for calling or texting instead of video chat for telehealth or telephonic visit. Let me just try to go over next steps. We saw the benefit of telehealth during the Covid 19 pandemic and not only did it allow patients to continue to access care during this difficult time, but it enhanced access or for those who live in a rural area because those patients, they do not have to drive two hours to their doctor's office. If you think about those with socioeconomic barriers, they do not have to leave their job and go to a medical office in the middle of the day as Julie mentioned.

And also for those who live in an area where there is a shortage of providers or physicians, it is hard for those clinicians or providers to recruit additional doctors to for example, like [indiscernible] County in California with telehealth where it would be so

much easier and where the patient's consent at their home in Del Norte County and have a telehealth visit with a provider in Sacramento or in Davis, where there are more availability or more options in terms of providers and choices.

And I think I will just end with that, David, this slide will show how CPCA priorities for the next two basically to maintain the current telehealth flexibilities as well as as support funding and possibility for broadband access and other priorities for our organizations.

David: thank you Trong. And why we keep that slide up on the screen because in the remaining a few minutes we will ask some questions with very brief 32nd responses but they do relate to these major issues going forward so I would like to ask our panelists, some of the assembled questions and we had many, thank you very much but if we can't get to them all, so we will invite you to send information to our speakers so we can get back to you directly.

Specifically, key issues around state lines and reimbursement about a number of time is there some place where we can find information around where reimbursement has been changed within different states and secondly, the status of now some of the compact and movement to approve services across state lines? Would appreciate if you have any suggestions of how people can find that information.

Mei: so you can look to CCHP for standards changes. We have a section devoted to state Covid changes and also this week we have the legislative roundup of all the legislative changes that would probably be useful to you as well. Just one thing about the compacts, we do have that information on our 50 state regarding what compacts are active in what states. One word of warning. There was a policy that was passed late last week or was issued late last week from HHS. It was an amendment to the PREP act which was an act basically to make sure that there was no liability for people who were treating folks with Covid and prescribing, or prescribing either vaccines or diagnostic tools. What they did in the amendment to it said that a telehealth provider who is working within their scope in the state and is doing a particular thing that they called a cover countermeasure which is basically the services that the PREP act covers which is a very narrow band of services will be able to do those things be a telehealth to a patient in another state that they are not licensed in. And we will have, we did a news alert on that. That is something new that came out late last week. We have a fact sheet for that that will be going out later this week. I will warn people if they are thinking this removes the licensure restriction, it does not, it removes it for a very specific situation when you are doing very specific things but it does preempt state licensure laws in the situation.

David: thank you Mei. One real quick questions people were asking are there sources for reimbursement for payment for training that they may not be aware of or that you could share, good places to turn to for a training for telehealth? Anything related to HRSA, stated issues would any of you have any recommendation for sources for payment for training, how to be either reimbursed or have coverage for training staff?

Mei: I can't think of anything off the top of my head. I think there may be some foundations who may offer some grants on that, but nothing specific to mine. I am trying to think if HRSA is doing anything specific to that. I will have to get back to that person. I can't think of anything off the top of my head at the moment.

David: sure we will differ on that one and one more and I'm going to take the prerogative that we will go a couple minutes over to wrap up for those who do have to leave there were a series of folks interested in Covid related topics such as, how do you see telehealth being used as we continue to expand testing as the vaccines become available, and other treatments, any other updates or sources we can turn to for looking at telehealth's role in this very important era of dealing with Covid?

Mei: David is this question specifically about how you use it clinically or is it more about how

David: it was generic.

Mei: so clinically I think there have been like a lot of examples of how people have been using it. Treatment of Covid. Especially if someone has milder symptoms and they are just working at home, policy wise again, I go back to the PREP act that was if you read it and you read between the lines that probably was a change made specifically to help with the vaccine distribution and/or the services that are being covered because administrator or providing vaccine covered with those services and so on a policy and I think those are things that will help facilitate that as well. And I will also say the prep act is not a permanent policy change that is done in this emergency situation so that's one of the temporary emergency situation preemption's too.

David: thank you and now we should wrap up due to time I would like to thank our speakers, Mei Kwong Julie Bates and Trong Le for some very important information and sharing I'd like to invite our participants that very important topics including mental health telehealth etc. having covered on the series it's available on the website. All the sessions including this when I put up on YouTube and the slides will be made available going forward. Also that we are moving into, as we move into 2021 we will be continuing our series. I would like to suggest that for those that asked questions regarding how to deal with the low income or disenfranchised populations, how to get equipment, how to look for different types of training both digital literacy and health literacy. And how to find new sources of funding. We will be addressing these issues as we move into 2021 particularly through the new programs established through our citrus initiatives. Which are lighthouse, which focuses on affordable housing and our activate program, which is looking at unity Health Center's building and a lot of the great work the California primary care Association you heard from Trong and looking at how we work with FQ HCs and rural communities.

I would like to once again thank our speakers. Also thank the sponsors for the program particularly the Gary and Mary West foundation for their ongoing support for this series and our colleagues internationally at the international Society for telemedicine in the

health and the transatlantic telehealth research network in particular for my colleagues at citrus and the University of California Davis Health Center who have done so much to bring this series to you. Again, these will all be available to you. We look forward to responding to the questions and we wish you a happy holiday season and we will join you with our next series starting in 2021. And again, thank you very much for your attention and have a great day.