



States Must Expand Telehealth To Improve Access to Sexual and Reproductive Health Care

By Osub Ahmed May 21, 2020

The COVID-19 pandemic has upended most people's way of life and drastically changed how the United States functions, particularly as it relates to health care. As a result of reduced access to routine care while the health system grapples with the pandemic, many patients are turning to telehealth, or remote virtual health services, to access basic care.¹ Telehealth represents the next frontier in health care delivery and has the potential to reshape the way people interact with their providers and the health care system overall. However, long-standing and systemic barriers inhibit many patients—particularly women, people of color, low-income individuals, immigrants, and young people—from accessing critical services through telehealth. The coronavirus pandemic has shined a light on these barriers,² especially when it comes to sexual and reproductive health (SRH) services.

Legislative and regulatory attacks against SRH providers have reached unprecedented levels in recent years, shrinking the pool of available family planning providers³ and cutting off access to in-person services such as well-woman visits and STI testing and treatment. Access to abortion care—an essential service—has also been eroded over the years by waves of targeted regulation of abortion providers (TRAP) laws, reason bans, and other restrictions.⁴ Prior to the pandemic, only a small fraction of SRH services—including contraception, medication abortion, sexually transmitted infection (STI) care, maternal health, and sexual assault services—were delivered via telehealth compared with reproductive health services generally, indicating in part a lack of access to these services,⁵ although this figure predates the COVID-19 pandemic and may have since changed. However, given the continued chipping away of access to in-person SRH services, telehealth represents an important mechanism through which SRH services can otherwise be delivered and one that can be leveraged by state and federal policymakers.

In fact, in response to the pandemic, the Centers for Medicare and Medicaid Services (CMS) released guidance in early March encouraging states to expand their telehealth services and offer providers more flexibility in virtual service delivery.⁶ The Coronavirus Aid, Relief, and Economic Security (CARES) Act—a federal relief package signed into

law in late March—built on the CMS’ recommendations, expanding Medicare flexibilities for telehealth service delivery as well as directing additional funding to programs run by, among other federal agencies, the U.S. Department of Health and Human Services (HHS) and the Federal Communications Commission.⁷ Since then, all states have updated or expanded their state telehealth policies in some way⁸ in order to reduce pressure on hospitals and clinics serving COVID-19 patients as well as limit patients’ exposure to the coronavirus when seeking health care services. While state policymakers are rightfully concerned about flattening the curve and reducing virus transmission, they must also ensure that SRH care remains accessible, including by expanding the availability of SRH services through telehealth.

Beyond the current public health crisis, telehealth presents an opportunity for state policymakers to think innovatively in order to transform their health systems and expand SRH care in both the short and long terms. This is particularly important for people living in rural regions as well as for communities of color, who have severely limited access to health care providers including family planning providers and OB-GYNs.⁹ Following an overview of the current telehealth landscape for SRH services, this issue brief offers several state recommendations to expand access to SRH services via telehealth during the COVID-19 pandemic and beyond, including:

- Removing coverage and reimbursement limitations to expand the list of originating sites, modalities, and provider types eligible for coverage and reimbursement
- Requiring payment parity between telehealth and in-person services
- Adopting multistate licensure compacts
- Investing in telehealth infrastructure

The brief then discusses the importance of investing in telehealth infrastructure as well as balancing patient privacy concerns with the need for better access to telehealth services.

The current state of SRH telehealth services

Telehealth describes the technologies and strategies used to deliver remote health care, including health-related counseling, education, and services. The modalities through which telehealth is delivered include real-time two-way interaction between the patient and provider by videoconference; store and forward, a form of asynchronous communication in which patient health information is sent to a provider who later reviews and offers treatment recommendations; remote patient monitoring, in which a provider monitors patient health outside of clinical settings, often in the home, through a home monitoring device; and mobile and phone-based health, or delivery of health information to mobile devices such as cell phones as well as audio-only communication.¹⁰

Regardless of the modality, telehealth technology is critical to overcoming the geographical, financial, and logistical barriers that many people face when trying to access SRH care in person. Increased regulatory and legislative attacks at both the federal

and state level have decimated reproductive health and family planning networks for decades and especially in recent years, reducing the number of providers as well as the scope of SRH care provided. Combined with prohibitive transportation costs and a lack of access to paid leave or child care, this puts in-person SRH care firmly out of reach for many in need of these critical services.

Contraceptive care

Fortunately, some SRH services are already being offered through telehealth. Contraceptive services, for example—including counseling, surveillance, and prescribing—can be accessed through a current provider or through one of several online platforms that connect patients with other prescribing providers.¹¹ Following an online consultation, providers typically either mail hormonal birth control directly to the patient or send the medication to a local pharmacy for pickup.

While contraceptive visits are the most common type of SRH service delivered through telehealth, utilization rates remain low when compared with in-person SRH services,¹² due in part to a lack of adequate insurance coverage. Coverage of telehealth visits with a patient's current OB-GYN or family planning provider depends on if the patient's insurance plan includes telehealth SRH benefits¹³—something that varies by state Medicaid program or private insurance plan. Lower payment rates for telehealth services can also disincentivize providers from adopting telehealth into their practices.¹⁴ In addition, many telehealth birth control platforms do not accept Medicaid or other public insurance; likewise for individuals with private insurance that covers telehealth, these platforms would be considered out of network and therefore may require cost-sharing, including paying out of pocket for consultation and delivery fees.¹⁵ Finally, most platforms and providers only prescribe to residents of particular states due to out-of-state licensing and online prescribing restrictions.¹⁶ Patients enrolled in public insurance programs—disproportionately low-income women and women of color¹⁷ as well as those who have lost their jobs and thus their employer-sponsored health insurance¹⁸—face some of the greatest barriers to accessing telecontraceptive care at this critical time.

Medication abortion

Medication abortion is also available virtually and has been shown to be as safe and effective as in-person abortion care. However, coverage of in-person abortion care on public and private insurance plans is significantly limited across the country;¹⁹ some states require that a licensed physician perform the procedure. Meanwhile, restrictions at the federal level require that medication be prescribed following strict Food and Drug Administration (FDA) protocols and also block federal Medicaid funding of abortions except under narrow circumstances. Those same limitations inhibit access to medication abortions through telehealth. In addition, prescribing providers usually must be licensed in the state where the patient resides, which restricts access to a number of SRH services for patients who live in states with large and ever-growing health care deserts.

Eighteen states—seven of which have enacted or attempted to enact alarming abortion bans during this pandemic²⁰—also require providers to be physically present during the procedure, which effectively blocks access to medication abortion via telehealth writ large.²¹ Nine of these states have among the lowest median household incomes in the country²² as well as large rural populations and communities of color—worsening the already tremendous barriers that people of color, those living in rural areas, and low-income people face when trying to access both telemedicine medication abortion and in-person care.

Unlocking access to telemedicine medication abortion at the federal level

The FDA regulates mifepristone—one of the two drugs used in medication abortion—through its Risk Evaluation and Mitigation Strategy (REMS) program. The FDA uses REMS to regulate high-risk drugs such as opioids and antipsychotic medications.²³ By contrast, mifepristone has been found to be safe and effective, with a low rate—0.2 percent—of reported adverse events.²⁴ Its inclusion in the REMS program, which requires that it be dispensed in clinics by certified providers, making it inaccessible to many patients, is medically unwarranted and limits providers' ability to offer medication abortion care in person or through telehealth.²⁵

Meanwhile, in the United Kingdom, the Department of Health and Social Care announced it was waiving restrictions on medication abortion in light of the COVID-19 crisis, permitting women to take both mifepristone and the second drug, misoprostol, at home after a phone or online consultation with a provider.²⁶ Ireland also started allowing providers to offer patients remote consultation for medication abortion drugs, while France relaxed restrictions around how many weeks into pregnancy the medication can be taken at home.²⁷ Given strong evidence for mifepristone's safety and other countries' actions supporting that fact, the FDA should move to undo these medically unnecessary restrictions in the United States.

Maternal health

Maternal health care, including prenatal and postnatal visits, can also be delivered virtually through telehealth. This is of growing interest to both patients and providers due to concerns about possible exposure to COVID-19 during in-person health care visits.²⁸ Pregnant women are already experiencing adverse effects during the coronavirus pandemic, including being separated from their partners, doulas, and even newborns during and after delivery.²⁹ An increasing number of pregnant women are now seeking out virtual home visiting services during their prenatal and postpartum periods as well as supports for delivery at home or in birthing centers, and hospitals are moving many of their obstetric services, such as prenatal check-ins, to telehealth platforms.³⁰ The recent alarming rise in maternal mortality and its accompanying stark racial disparities³¹—as well as the fact that women, particularly women of color, disproportionately live in maternal health care deserts where access to hospitals and providers offering obstetric care is severely limited or access to that care is restricted³²—further underscores the

importance of connecting pregnant women to maternal health supports such as virtual home visits. It also emphasizes the need for sustained and substantive policy change related to improved telehealth maternity care coverage and benefits. Telehealth should be utilized to address both poor maternal health outcomes and the racial disparities that underpin those outcomes—and it should play a part in the larger federal response to the U.S. maternal health crisis.

Opportunities for state innovation in telehealth and SRH services

The CMS has taken significant steps to lift restrictions on telehealth during the pandemic, and the HHS Office for Civil Rights has waived enforcement of the Health Insurance Portability and Accountability Act (HIPAA)—the federal law restricting release of medical information—violations during this period.³³ The CARES Act has built upon this by expanding Medicare and Medicaid telehealth flexibilities as well as increasing funding for different federal agencies, while the recently introduced House bill, the Health and Economic Recovery Omnibus Emergency Solutions (HEROES) Act, seeks to direct additional funding to programs that improve broadband infrastructure and technology.³⁴ However, while positive, these federal actions do not go far enough; individual states must do more work to ensure that their residents have access to telehealth and, importantly, SRH services.

The following recommendations address barriers that existed before the pandemic but have been brought into stark view because of the urgent need to rapidly expand and adopt telehealth. These recommendations were crafted with SRH service expansion in mind but may also apply to other areas of health care delivery, as they are focused on strengthening telehealth services writ large.

Remove coverage and reimbursement limitations

A significant barrier to accessing SRH services via telehealth is a lack of adequate coverage by both public and private insurance plans. As mentioned previously, the CMS has recently encouraged states to take advantage of their significant flexibility when it comes to determining telehealth coverage in their Medicaid fee-for-service programs and managed care arrangements—including whether and how such coverage is offered and what types of providers and services are covered.³⁵ States can also require private insurers in their state to reimburse providers for telehealth services.³⁶ As such, states have several tools at their disposal to improve access to telehealth services, including expanding the list of eligible originating sites, modalities, and provider types.

Expand the list of eligible originating sites

Twenty-three states have coverage requirements related to where patients are located when receiving care—called originating sites—although the list of eligible originating sites has grown in recent years.³⁷ In fact, prior to the pandemic, 19 states allowed a patient's home to serve as an originating site.³⁸ Since the pandemic began, at least 28 states now permit patients to receive health care from their homes or at a location of their choosing.³⁹

It is critical that states that have not yet done so work to expand the list of eligible originating sites to include patients' homes. Doing so will improve telehealth access, such as telecontraceptive services and remote patient monitoring for maternal health care.

Broaden the types of permitted telehealth modalities

While all states cover at least one telehealth modality under their Medicaid programs, there are a number of coverage restrictions related to the services these modalities can host.⁴⁰ For instance, while 50 states and Washington, D.C., require coverage of live video services, six states explicitly prohibit coverage of abortion care administered via live video. Another six states only cover live video for specific specialties, primarily behavioral health. This excludes critical services such as contraception, pregnancy care, and other SRH services.

As a result of the pandemic, dozens of states are taking advantage of their Medicaid flexibility vis-a-vis telehealth, with at least 44 states expanding their telehealth modalities to include audio-only technology and nonpublic-facing video platforms such as Skype, Zoom, and FaceTime, which are critical for patients who do not have access to expensive electronic equipment. Health care providers were previously not permitted to use the aforementioned video platforms for telehealth due to HIPAA requirements, although enforcement of this requirement has been suspended during the coronavirus pandemic; this has important benefits and expands accessibility of telehealth but should be monitored to ensure that patients' security and privacy remain protected in the long term. Expanding modalities is an important part of making telehealth more accessible: Studies have shown that Black and Hispanic patients are more likely than white patients to access their health data through smartphones instead of tablets or laptops.⁴¹ Any attempts to make telehealth more accessible to patients of color must include promoting the use of mobile-based nonpublic-facing platforms. All states should consider making these changes permanent beyond the pandemic, in addition to eliminating from telehealth coverage the explicit exclusion of SRH services such as abortion.

Allow additional provider types to offer telehealth

Some states only permit reimbursement when care is administered by specific providers, such as physicians, which limits the provision of telehealth services to a smaller pool of providers. When it comes to medication abortion, 33 states allow only licensed physicians to prescribe the medication, despite evidence demonstrating that advanced practice clinicians (APCs)—including nurse practitioners, physician assistants, and certified nurse midwives—can also deliver comparably safe and effective care based on their training and expertise, in spite of limitations imposed by scope-of-practice laws.⁴² While at least 12 states have explicitly allowed APCs to bill for telehealth services, more states must expand the pool of available providers, who are under immense strain during this emergency. Likewise, midwives face barriers to providing maternal health care via telehealth, from licensing and credentialing requirements to ineligibility for Medicaid reimbursement in some states, while doulas are not included in any states' list of eligible

providers.⁴³ States must expand the list of providers permitted to offer telehealth care to include APCs—many of whom are critical in delivering SRH services such as contraception, medication abortion, and maternal health—as well as midwives and doulas in order to make SRH care more accessible.⁴⁴

Require payment parity

States can also improve telehealth coverage by mandating payment parity, or requiring that telehealth services are reimbursed at the same rate as in-person services in Medicaid as well as employee and retiree plans. At least 32 states have mandated telehealth payment parity across public insurance programs and/or state-regulated health plans, but many other states have not directly addressed this issue. This is a key barrier to wider adoption of telehealth because it allows for telehealth services to be reimbursed at lower rates. It is important to note that states would not need to apply for a state plan amendment in order to require their state Medicaid programs to reimburse providers for telehealth services at higher rates, as long as those rates are offered at the same rate as in-person care.⁴⁵ As with other health care services, requiring payment parity is important for increasing access to SRH telehealth services, as it incentivizes providers to adopt telehealth and ensures they receive similar rates regardless of how services are delivered.

Adopt multistate licensure compacts

Numerous states have strict licensing requirements when it comes to providing telehealth services, such as a requirement that providers are licensed in the state where they are offering services. While nearly all states have introduced flexibility in licensure during the COVID-19 pandemic,⁴⁶ they must use these efforts as a starting point to develop more permanent solutions to address these restrictions once the crisis has ended. This is critical for SRH services in light of the nation's contraception and abortion deserts, which force many patients to cross one or even several state lines to obtain needed in-person SRH care.⁴⁷

One solution to the licensing barrier is for states to enter into multistate compacts, through which a provider licensed in one state can practice in or receive expedited licensing from other states participating in the contract.⁴⁸ To date, 29 states and Washington, D.C., have adopted the Interstate Medical Licensure Compact, while 34 states have adopted the Nurses Licensure Compact.⁴⁹ Additional states should consider joining these compacts to ensure that both their providers as well as providers in other states have the flexibility to offer SRH services remotely.

Invest in telehealth infrastructure

Establishing the needed infrastructure to deliver telehealth services is a critical but costly step. For example, telehealth platforms must be compliant with HIPAA and, if possible, integrated with existing electronic health record systems.

Thankfully, the federal government has made substantial investments in state and local telehealth infrastructure, including expanding broadband access, through the CARES Act.⁵⁰ This large federal investment is critical: Without affordable and reliable access to broadband and wireless, telehealth will be largely inaccessible to many patients, particularly people of color, low-income people, and young people, and SRH service utilization in particular will remain low. Increased investment in the Federal Communications Commission's Lifeline program—which provides low-income consumers with discounted phone and broadband services—is also critical to ensuring access to telehealth.⁵¹

Investments in equipment for both patient and provider use is also needed; many patients do not have the financial means to afford required hardware, such as laptops. Meanwhile, smaller independent practices have been especially hard hit by the pandemic and are struggling to ensure their providers have the equipment they need to conduct telehealth services—a fact that is made even more challenging for providers offering SRH services given the heightened sensitivity and need for patient privacy related to these services. Any federal financial support states receive to improve their telehealth capacities should be directed not only toward significant investment in broadband and wireless services but also toward financial support to patients and providers who otherwise cannot afford needed equipment.

In addition, there are several barriers that make the implementation and utilization of telehealth challenging for both providers and patients.⁵² For providers, these barriers include a lack of training on how to deliver virtual care; confusing billing procedures; and a lack of integration with existing electronic health record systems. States must work to address these particular concerns through increased funding for provider training programs on virtual care delivery and billing as well as to help providers fully integrate telehealth records with existing electronic health records. While more medical schools and teaching hospitals are providing students with classroom and clinical training in telehealth—almost 50 percent of medical schools offered telemedicine courses in the 2016-17 academic year⁵³—the current pool of providers continues to need greater training and support. This has been laid bare by reports of patients receiving exorbitantly high—and incorrectly calculated—bills.⁵⁴ Training among SRH providers is also vital, given the shrinking provider pool and difficulty in providing in-person services. Providers such as Planned Parenthood have recently expanded their telehealth services to all 50 states, but for smaller practices, the additional financial support to train staff on care delivery and billing is key.⁵⁵

For patients, challenges to accessing telehealth are numerous: a lack of affordable and reliable broadband and wireless access and coverage; a lack of access to comprehensive and affordable health coverage; and significant economic disparities, to name a few. There is also a digital divide in the United States: 58 percent and 57 percent of Black and Hispanic adults, respectively, own a laptop or desktop computer, compared with 82 percent of white adults,⁵⁶ and one-third of people living in rural areas do not have

access to a broadband and wireless internet connection at home.⁵⁷ This divide, coupled with inadequate or restricted health coverage for SRH services,⁵⁸ has only exposed the issues women of color have faced in accessing SRH services via telehealth prior to the pandemic and the continued barriers they face in accessing these services today. In addition to addressing issues related to broadband and wireless access and health coverage, states should attempt to grow the list of permitted modalities, including platforms such as FaceTime and Zoom, which are lower-cost options that make SRH telehealth more accessible, while the companies that own these platforms may need to adapt their systems to be more HIPAA compliant.

The importance of balancing increased telehealth access with privacy considerations

While the rapid adoption of telehealth has been a positive development during this crisis, it is vital that federal and state regulators, policymakers, and providers continue to promote and follow strong safeguards to protect patients' sensitive personal health information. This is particularly important for patients seeking SRH care given the sensitive nature of these services.

Telehealth is replete with third-party groups and troves of electronic health data, some of which could be used for profit or marketing purposes. Some state Medicaid programs include specific instructions in their Medicaid manuals regarding telehealth and patient privacy,⁵⁹ but many reference HIPAA standards. These standards, established in 1996, designate health provider organizations and insurance plans as covered entities and require them to protect personal health information.⁶⁰ In an effort to encourage the adoption of telehealth, the HHS Office for Civil Rights announced in March that it would relax its enforcement of penalties for HIPAA violations during the COVID-19 pandemic.

However, the list of actors involved in health data has rapidly expanded in the past two decades and goes beyond what Congress envisioned when HIPAA was passed.⁶¹ It now includes mobile app companies that collect sensitive information such as health tracking and geolocations, highlighting the strong need for a national data privacy law since many of these apps fall into gaps not covered by HIPAA. This is particularly concerning for SRH care during this pandemic; when provided under the new HHS waiver, this type of care is ripe for abuse, and privacy lapses can lead to any number of negative consequences for patients, including increased premiums on plans that do not offer preexisting condition protections and threats to personal safety.⁶² Beyond compliance with current HIPAA requirements, states should continue to expand specific privacy protection requirements for actors involved in health data collection, transfer, and storage. For example, states should adopt stronger standards to ensure that business associates of covered entities, rather than just covered entities, continue to comply with privacy rules under HIPAA as well as notify patients when their health information was compromised.

As states work to improve the availability and affordability of SRH telehealth services—a vital step to ensure telehealth is a meaningful option—they should also simultaneously strengthen privacy protections, as suggested above, to assure patients that their sensitive personal health information, especially information related to SRH, will be kept safe and not used by other actors without explicit and informed consent. Indeed, these commonsense advancements in technology should be evaluated at the end of the pandemic to ensure their benefits are not lost but that key privacy or security protections are also not overlooked.

Conclusion

The current public health crisis has highlighted the critical role that telehealth can play in expanding health care access and dismantling barriers that have prevented certain groups, such as women of color and low-income patients, from accessing quality, affordable, and timely health care. States have several tools at their disposal to improve telehealth accessibility, and their investments will not only help providers to respond to the current pandemic and save lives by limiting exposure to the coronavirus but also function as a longer-term investment in expanding access to health care services, including SRH care. These tools include removing coverage and reimbursement limitations; requiring payment parity between telehealth and in-person services; adopting multistate licensure compacts that allow providers to offer services across state lines; and investing in telehealth infrastructure, including affordable and reliable broadband and wireless service, as well as needed technology and equipment.

States must also balance this expanded availability of services with strong guardrails that ensure privacy protections for patients' health information—a particularly important consideration for SRH services.

It is incumbent on states to leverage the increased attention and federal financial support for telehealth to strengthen and expand their telehealth services and infrastructure during this pandemic; such actions will only pay off in the long term and enhance the health and well-being of people across the country well into the future.

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