

**STATEMENT OF
COMMISSIONER GEOFFREY STARKS**

Re: *In the Matter of COVID-19 Telehealth Program*, WC Docket No. 20-89, *Promoting Telehealth for Low Income Americans*, WC Docket No. 18-213; Report and Order and Order on Reconsideration

When we launched the COVID-19 Telehealth Program last April, it was clear that telehealth would play a critical role in addressing COVID-19. Even early in the pandemic, experts agreed that receiving care remotely could both meet many patients' needs and help prevent community spread of the coronavirus. I have been a proud champion of telehealth, and I was pleased that we were able to launch the program so quickly in those early days. And I remain proud that our first phase of grants has helped improve the healthcare available to so many Americans.

Today, nearly a year later, we have ample evidence that telehealth made an enormous difference in our nation's pandemic response. Researchers at the Urban Institute found that during the first six months of the pandemic one-third of Americans had a telehealth visit to discuss their own healthcare.¹ There have been particularly striking increases in telehealth use by low-income Americans. Between March and June 2020, the Centers for Medicare and Medicaid Services found that telehealth visits for Medicaid and Children's Health Insurance Program beneficiaries increased by more than 2600 percent compared to the same period in 2019.² Those beneficiaries received more than 34 million telehealth services in just four months. Those strong adoption rates are truly remarkable!

Through tens of millions of virtual visits, patients and healthcare providers have reduced in-person contacts and maintained social distancing—important measures to prevent spread of the coronavirus. But patients clearly saw other benefits that had piqued interest in telehealth even before the pandemic—increasing access to specialists, mitigating challenges like travel and health conditions that keep people from seeing doctors, and reducing costs. Those benefits are likely to make expanded access to telehealth a lasting legacy; three-quarters of people who used telehealth during the pandemic say they are very or somewhat likely to continue doing so.³

Telehealth can make a difference for all Americans, particularly low-income communities of color. Rush University Medical Center is located in a majority Black neighborhood on the West Side of Chicago, the city with the largest gap in life expectancy in the United States: nearly 30 years.⁴ When I visited Rush before the pandemic, I learned about its novel use of telehealth to treat cancer and diabetes in its neighborhood. But the hospital's telehealth efforts went into overdrive during the pandemic, as Rush became ground zero in Chicago's fight against COVID-19. Between April and May 2020, it received

¹ Urban Institute, *One in Three Adults Used Telehealth during the First Six Months of the Pandemic, but Unmet Needs for Care Persisted* (January 2021), https://www.urban.org/sites/default/files/publication/103457/one-in-three-adults-used-telehealth-during-the-first-six-months-of-the-pandemic-but-unmet-needs-for-care-persisted_1.pdf.

² Centers for Medicare and Medicaid, *Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19 at 6* (2020), <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf>.

³ The Harris Poll, *Telehealth: The Coming 'New Normal' for Healthcare*, <https://theharrispoll.com/telehealth-new-normal-healthcare/> (last visited Mar. 29, 2021).

⁴ Press Release, NYU Langone Health, *Large Life Expectancy Gaps in U.S. Cities Linked to Racial & Ethnic Segregation by Neighborhood* (June 5, 2019), <https://nyulangone.org/news/large-life-expectancy-gaps-us-cities-linked-racial-ethnic-segregation-neighborhood>.

more than 600 patient transfers from surrounding safety net hospitals, most of whom were COVID-19 positive, and many of whom were either uninsured or on Medicaid.⁵ In response, Rush invested in telehealth technology that allowed doctors and staff to monitor and communicate with COVID-19 patients from the patients' homes. The hospital used the same technology to maintain continuity of care for patients with other conditions who couldn't visit the hospital because of social distancing restrictions.

It's also important to acknowledge the emotional toll of the last year. Communities of color have been affected in many ways by the COVID-19 pandemic, not only with disproportionate losses of employment and businesses, but also with higher rates of infection and death.⁶ Yet these same communities lack equal access to mental health and substance abuse resources.⁷ Telehealth has proven it can be a valuable tool to connect our most vulnerable with the resources they need to receive treatment and stay in touch with counselors and other support.

With all these benefits in mind, I am pleased to approve today's Order, which extends the COVID-19 telehealth program and adds important transparency to the process. In this Order, applicants and other interested parties will be able to see with particularity how their proposals will be evaluated. I am especially pleased, given the disproportionate burden low-income Americans have borne during this pandemic, that we will give significant weight to applications proposing to serve low-income communities. In particular, I thank my colleagues for agreeing to my edits that will allow us to more accurately credit an applicant's service to impoverished communities. The draft order initially measured poverty only at the county level. But we know that this method can sometimes fail to identify poverty in urban areas within a more affluent county. For example, the city of Buffalo, New York is located in Erie County. Under the draft's original language, applications from Erie County would not have received points for serving a low-income area because it has a poverty rate of 13.3 percent, just below the national median.⁸ While this figure is significant, Buffalo's city-wide poverty rate is over 30 percent.⁹ As discussed below, it's the same story in cities across the country.

The changes we made to the draft will better ensure that the highest poverty areas receive a high level of our attention. Today's Order ensures that these areas will not be overlooked by directing USAC to determine the poverty rate of both the county and the census tract for health care provider applicants. In assessing an application, if it would receive more points using the census tract poverty rate instead of the county measure (or vice versa), USAC will award the application the higher points available between the two. Here is a sampling of cities with such census tracts:

⁵ Bill Siwicki, *At Rush, patient engagement suite increases pandemic-era rounds by 247%* (Aug. 13, 2020), <https://www.healthcareitnews.com/news/rush-patient-engagement-suite-increases-pandemic-era-rounds-247>.

⁶ Centers for Disease Control and Prevention, *Health Equality Considerations and Racial and Ethnic Minority Groups* (Feb. 12, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>.

⁷ The Office of Minority Health at the U.S. Department of Health and Human Services, *Minority Mental Health Awareness Month*, <https://www.minorityhealth.hhs.gov/omh/content.aspx?ID=9447> (last visited Mar. 29, 2021).

⁸ United States Census Bureau, *Quick Facts: Erie County, New York*, <https://www.census.gov/quickfacts/eriecountynewyork> (last visited Mar. 29, 2021).

⁹ United States Census Bureau, *Quick Facts: Buffalo city, New York*, <https://www.census.gov/quickfacts/buffalocitynewyork> (last visited Mar. 29, 2021).

- Anaheim, CA
- Anchorage, AK
- Ann Arbor, MI
- Arlington, VA
- Austin, TX
- Buffalo, NY
- Carlsbad, NM
- Charleston, SC
- Charlotte, NC
- Chicago, IL
- Denver, CO
- Honolulu, HI
- Huntsville, AL
- Kansas City, MO
- Madison, WI
- Marietta, GA
- Minneapolis, MN
- New Haven, CT
- Phoenix, AZ
- Pittsburgh, PA
- Reno, NV
- Seattle, WA
- Sioux Falls, SD
- Worcester, MA

With vaccination numbers increasing, the end of the coronavirus pandemic is hopefully in sight. In the midst of those welcome developments, we must be mindful that there are still difficult months ahead. I thank all the Commission staff who developed this Order so that the COVID-19 telehealth program can support more healthcare providers and patients as we work to put the pandemic behind us.