IDAHO’S COVID-19 RESPONSE: MECHANISMS TO MAINTAIN A LASTING INCREASE IN ACCESS TO HEALTH CARE

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1. Note from the Author: This Comment recounts a moment in history. It was submitted to the Idaho Law Review in the Spring of 2022 amid the public health emergency necessitated by the COVID-19 pandemic. Since that time, there have been many changes. COVID-19 positivity rates, and prevalence of sickness and death attributable to the virus, has waned. Moreover, the legal and regulatory landscape with respect to many of the waivers and regulatory flexibilities taken in response to COVID-19 to increase access to care, such as medical provider licensure with respect to telemedicine, physician assistant limitations, and crisis standards of care, have likewise changed. Namely, in the wake of the COVID-19 pandemic, bills aiming to increase access to health care through easing restrictions on medical licensure, telemedicine, permitted telemedicine modalities, reimbursement of certain services delivered via telemedicine, and the like have been proposed, both in Idaho and elsewhere. Some have become law while others have not. Specifically, in Idaho, the Virtual Care Access Act, which became effective on July 1, 2023, amended existing law to make the practice of telehealth in Idaho easier for out-of-state providers who do not hold an Idaho medical license. See IDAHO CODE §§ 54-5701–5714 (2023). Under the Virtual Care Access Act (the Act), a provider who does not hold an Idaho medical license but nonetheless holds a medical license in another jurisdiction and is in good standing may render virtual care (i.e., technology-enabled health care services) to an Idaho patient so long as the rendering of services falls within one of the Act’s safe-harbor provisions. Id. Namely, to render virtual care without holding a requisite in-state medical license, a non-Idaho-licensed provider must either (1) have an established patient-provider relationship with the patient and the patient is temporarily in Idaho; (2) have an established patient-provider relationship with the patient and be providing temporary or short-term follow-up health care services; (3) be employed or contracted by an Idaho facility or hospital to provide services for which the provider has been privileged or credentialed; (4) be rendering services during a disaster and providing follow-up services; (5) provide health care services in preparation for a scheduled in-person visit; or (6) consult with or refer the patient to an Idaho-licensed provider. IDAHO CODE § 54-5713. If one of the above provisions applies, a provider who does not hold an Idaho medical license may render virtual care to an Idaho patient, however, the care must comport with the Idaho community standard of care that would apply if the interaction were in an in-person setting. IDAHO CODE § 54-5706. The passage of the Virtual Care Access Act represents significant progress with respect to increasing access to health care, but there is room for more. While the Act seeks to make it easier to render virtual care to Idaho patients by out-of-state providers not holding an Idaho medical license, providers can easily run afoul of the law, and be subject to criminal and civil penalties, if the scope of their care falls outside of the narrow exceptions set forth in the Act. As such, while the Act increases access to care, it only increases access to the types of care that happen to fall within its well-delineated exceptions to Idaho law. Accordingly, this Comment argues that, although the passage of the Virtual Care Access Act in 2023 is undoubtedly a giant step in the right direction towards increasing access to care, there remains opportunity for the Idaho Legislature to further increase access to safe health care for all Idahoans by permanently enacting all waivers and regulatory flexibilities necessitated by the COVID-19 pandemic surrounding the provision of telemedicine in Idaho. See discussion infra Section V–VII.
Health care access is a complex issue that touches individuals across the United States, from congested inner-city denizens to remote, rural communities. There are numerous components to the health care access problem, many of which are connected or even causal. A number of these widespread issues such as lack of transportation, lack of insurance, a paucity of licensed health care providers, and dependence on Medicaid disproportionally affect the residents of Idaho owing to the rural nature of much of the state and varied availability of health care infrastructure. It is well studied that lack of health care access leads to poor health outcomes.

A number of changes were made to the way in which health care is delivered in the midst of the global COVID-19 pandemic. Notably, in Idaho and elsewhere, regulations regarding telemedicine underwent numerous changes in order to allow health care providers to reach the largest number of patients possible—even allowing for medical consultation across state lines from providers not holding an in-state license to nonetheless practice medicine. In anticipation of the need for more health care providers during pandemic surges, unprecedented changes were enacted regarding physician licensure, allowing increased reciprocity between states so that licensed physicians in good standing were able to practice in a number of participating states without having to undergo the arduous applications, lengthy wait times, and costly fees of traditional licensure. Rules regarding Physician Assistant supervision were loosened in order to further increase the workforce of practicing medical professionals. Additionally, in Idaho, crisis standards of care were enabled due to surges in patient volumes and critical overwhelming of available resources, allowing providers and health systems to deliver scarce resources to those most in need. However, while Idaho’s approach to deregulation undoubtedly helped increase access to health care when it was needed most, many questions remain: Did it work? Was it enough? Will it last?

This Comment explores issues surrounding access to health care both nationally and locally in Idaho and assesses how changes made in response to the global COVID-19 pandemic have positively and negatively affected health care access and outcomes. Data is emerging in real-time showing the pros and cons of many of the changes enacted such as increased telehealth interactions and greater flexibility in rendering safe and effective care. Moving forward,
changes to laws, regulations and policies that continue the ease of medical licensing requirements, enhance telemedicine programs, and widen advanced practice practitioner’s scope of practice are sustainable mechanisms to address and improve access to health care in Idaho and beyond.

TABLE OF CONTENTS

| ABSTRACT | .......................................................... | 534 |
| TABLE OF CONTENTS | ....................................................................... | 535 |
| I. BACKGROUND | ..................................................................... | 535 |
| | A. Defining Access to Health Care | ........................................ | 536 |
| | B. Health Care Access Issues in the United States | ................................ | 537 |
| | C. Health Care Access Issues in Idaho | .................................... | 542 |
| II. COVID-19 PANDEMIC | ..................................................................... | 545 |
| | A. COVID-19 Pandemic Generally | ........................................ | 545 |
| | B. COVID-19 in Idaho | ............................................................. | 546 |
| III. CHANGES TO IDAHO’S HEALTH CARE SYSTEM IN RESPONSE TO THE COVID-19 PANDEMIC | ..................................................................... | 550 |
| | A. Telemedicine & Licensing | ........................................ | 550 |
| | B. Physician Assistant Supervision Limits | ................................ | 551 |
| | C. Crisis Standards of Care | .................................................... | 553 |
| IV. IMPACT OF IDAHO’S COVID-19 RESPONSE ON ACCESS TO CARE | ........................................ | 554 |
| | A. Licensing Impacts | ......................................................... | 554 |
| | B. Telehealth Impacts | ......................................................... | 555 |
| | C. Physician Assistant Oversight Impacts | ........................................ | 556 |
| | D. Provider Discipline Impacts & Patient Safety Concerns | ................................ | 557 |
| V. INCREASED AVAILABILITY OF TELEHEALTH CAN IMPROVE ACCESS & PATIENT OUTCOMES | ........................................ | 560 |
| | A. Improving Access | ......................................................... | 560 |
| | B. Improving Patient Outcomes | .................................................. | 562 |
| VI. BARRIERS TO MAINTAINING INCREASED ACCESS TO CARE THROUGH TELEHEALTH IN IDAHO | ........................................ | 564 |
| | A. Technological Barriers | ...................................................... | 564 |
| | B. Economic Barriers | ......................................................... | 565 |
| | C. Regulatory Barriers | ......................................................... | 566 |
| VII. CONCLUSION | ..................................................................... | 567 |

I. BACKGROUND
A. Defining Access to Health Care

Access to health care services is an oft-cited subject in much of the scholarship surrounding the shortcomings of the modern American health care system. This is unsurprising, given that, despite the “United States spend[ing] more money than any other country in the world on health services . . . Americans still struggle to access . . . care.”2 While America spends over $3.6 trillion dollars per year on health care, access to health care services in the United States, and lack thereof, remains a serious problem.3 But, in the context of health care, what exactly is access? There are many ways to define this complex concept.4

In 1981, two leading scholars sought to define the rough contours of “access” by setting forth the multi-faceted “5 A’s” of Availability, Accessibility, Accommodation, Affordability, and Acceptability to delineate access as a “concept representing the degree of ‘fit’ between the clients and the system.”5 Other scholarly definitions suggest that “access might describe either the potential or the actual entry of a given individual or population group into the health care [delivery] system.”6 Yet other scholars have characterized health care access to include issues as far-reaching and disparate as the availability of providers and services in rural areas, an individual’s geographic proximity to care, the ease of contacting a health care provider, the length of time it takes to get an appointment, the adequacy of insurance and the types of insurance accepted, provider willingness to participate in public insurance programs such as Medicare and Medicaid, the availability of transportation to access health care services, and discrimination in health care on the basis of race, gender, disability, socioeconomic status, and other characteristics.7 Perhaps more concisely, the National Academies of Sciences, Engineering, and Medicine (formerly known as the Institute of Medicine) has characterized access to health care as the “timely use of personal health services to achieve the best possible health outcomes.”8

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accepted definitions, health care access is a complex concept. But why is that the case? A closer look into the concept reveals the likely culprit; a myriad of factors operate in conjunction to create substantial barriers to access.

B. Health Care Access Issues in the United States

One major barrier to health care access is the shortage of health care professionals. In November 2021, the U.S. Department of Health and Human Services’ Health Resources & Services Administration Database indicated that in the United States there are 84 million people living in 7,483 Health Professional Shortage Areas—a shortfall that would require 14,886 primary care practitioners to address. While there are many potential explanations for this disparity, experts largely attribute the shortage to the U.S. population aging, population growth, overall supply and demand imbalance, and a significant increase in the insured population following the passage of the Affordable Care Act.

Unfortunately, it does not appear that this practitioner shortfall will end any time soon. This is because it is projected that over the next decade demand for physicians will continue to outpace supply. According to one study that assessed current physician shortfalls and forecasted physician demand from 2017 through 2030, the chasm between the demand for and the supply of physicians is anticipated to continue to grow wider—ultimately reaching a national deficit of 139,160 physicians by 2030. As a result, thirty-four of fifty states will face significant physician shortages by 2030. This is concerning as, absent the growth of mechanisms that have the potential to increase existing provider efficiency, if more providers are not introduced into the health care system to level the future supply-demand imbalance, existing providers will be forced to see more patients in order for current levels of access to remain static.

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11. Xiaoming Zhang et al., Physician Workforce in the United States of America: Forecasting Nationwide Shortages, 18:8 HUM. RES. FOR HEALTH 1 (2020); see also Sahdev, supra note 2, at 1823.
12. Zhang et al., supra note 11, at 1.
13. Id. at 8.
14. Id. at 4.
The lack of access to health care is especially acute in the nation’s rural areas. Roughly 60 million Americans—one fifth of the population—live in rural areas as defined by the U.S Census Bureau. For these 60 million people, reduced access to health care as compared to their urban counterparts is evidenced by comparatively higher levels of chronic disease, poorer health outcomes, reduced likelihood of health insurance, higher infant mortality rates, higher rates of unintentional injury coupled with greater mortality due to accidents, higher rates of heart disease, and increased incidents of suicide. Further, rural Americans are more likely to die from heart disease, cancer, chronic lower respiratory disease, and stroke than their urban counterparts. While some commentators attribute worsened rural resident health outcomes, in part, to the differing health-seeking behaviors of rural residents as compared to those living in urban areas, it remains evident that reduced access to health care in rural areas significantly contributes to disparate results between urban and rural communities. For example, a 2010 study found that while seventeen percent of the U.S. population lived in rural areas, only twelve percent of total hospitalizations and six percent of inpatient care was delivered in a rural hospital setting. As this disparity illustrates, there is a clear need for better access to health care in rural America. According to the National Rural Health Care Association

The obstacles faced by healthcare providers and patients in rural areas are vastly different than those in urban areas. Rural Americans face a unique combination of factors that create disparities in health care not

15. While defining what constitutes a rural area is not an exact science, it is widely accepted that sparseness of population is a determinative factor. For example, the U.S. Census Bureau does not explicitly define “rural.” Rather, according to the Census Bureau, rural areas include any geographic area that is not defined as urban. U.S. CENSUS BUREAU, DEFINING “RURAL” AREAS 2 (2019), https://www.census.gov/content/dam/Census/library/publications/2019/acs/ACS_rural_handbook_2019_ch01.pdf. An urban area is defined in two distinct ways. Urbanized areas are areas which contain 50,000 or more people. Urban clusters are areas which contain between 2,500 and 50,000 people. Id. Urbanized areas and urban clusters are delineated primarily by population density, but the U.S. Census Bureau also considers land use and land cover, as well as distance criteria, in determining whether to include a particular territory in an urban area. Id. at 3.


19. Douthit et al., supra note 17, at 612.

20. Id.
found in urban areas. Economic factors, cultural and social differences, educational shortcomings, lack of recognition by legislators and the sheer isolation of living in remote rural areas all conspire to impede rural Americans in their struggle to lead a normal, healthy life.\textsuperscript{21}

While the obstacles to health care access shared by urban and rural residents are numerous, rural residents face many barriers to health care access to a more significant degree than their urban counterparts. First, geographic distribution of health care facilities, services, and providers plays a major role in health care access, utilization, and treatment outcomes.\textsuperscript{22} One study looked to the disparities between the distribution in rural and urban Alaska and New Mexico of the following health care providers: physicians practicing in six practice areas, physician assistants, registered nurses, and nurse practitioners.\textsuperscript{23} The study uncovered significant disparities between the number of providers in rural versus urban areas and confirmed that rural residents face significant disparities for access to care providers.\textsuperscript{24} Importantly, this disparity increases as the level of education and need for specialization increase.\textsuperscript{24} As an illustrative example, the study found that in Alaska there is one OB/GYN for over 50,000 rural residents whereas there is one OB/GYN for every 5,000 urban residents.\textsuperscript{26} While this study illustrates the rural-urban disparity in Alaska, the overall lack of medical specialists and subspecialists servicing rural areas is not limited to the non-contiguous United States. According to one study, in the United States “[t]here are 40 subspecialists for every 100,000 patients in rural areas compared [with] 134 [subspecialists] for every 100,000 patients in urban areas”—a 235% variation.\textsuperscript{27} Accordingly, rural residents not only

\begin{notes}
\textsuperscript{21} About BHRA, NRHA, https://www.ruralhealth.us/about-nrha/about-rural-health-care (last visited Apr. 5, 2023); see also Douthit et al., supra note 17, at 612.

\textsuperscript{22} Tami L. Thomas et al., Overcoming the Triad of Rural Health Disparities: How Local Culture, Lack of Economic Opportunity, and Geographic Location Instigate Health Disparities, 73 HEALTH EDUC. J. 285, 288 (2014).

\textsuperscript{23} Mark E. Johnson et al., Rural-Urban Health Care Provider Disparities in Alaska and New Mexico, 33 ADMIN. AND POL’Y IN MENTAL HEALTH AND MENTAL HEALTH SERVS. RSCH. 504, 504–05, 506 tbl.1 (2006).

\textsuperscript{24} Id. at 506.

\textsuperscript{25} Id.

\textsuperscript{26} Id.

\textsuperscript{27} James P. Marcin et al., Addressing Health Disparities in Rural Communities Using Telehealth, 79 PEDIATRIC RSCH. 169, 170 (2016).
\end{notes}
face a shortage of primary care providers, but also a shortage of specialists and subspecialists as compared to their urban counterparts.  

Rural residents’ geographic proximity to care also serves as a barrier to health care access. Rural residents, by definition, are more geographically isolated than those living in an urban environment who generally have more health care facilities available. This isolation, and the transportation barriers that result, can prove to be prohibitive when it comes to accessing care. This is because studies have shown that the further a patient needs to travel for care, the less likely they are to make the trip. Further, when patients do seek treatment, they may be more likely to pursue radical treatment options or treatment that is not tailored to their condition. One study showed that rural breast cancer patients were more likely to seek radical surgery instead of radiation therapy when they lived far away from a radiotherapy facility, whereas patients within a fifteen-mile radius of a rural radiotherapy facility experienced a sixteen percent reduction in mastectomy rates “as radiotherapy became available as an alternative to surgery.” Another study showed that patients with Multiple Sclerosis (MS) that lived a considerable distance from specialist services sought MS care from non-specialized general practitioners that were more accessible.  

Beyond chronic conditions, distance and transportation barriers also serve to deter patients from seeking preventative care, which can have the downstream effect of poorer health outcomes. Patients that live a considerable distance from primary care providers are less likely to seek preventative care such as check-ups and immunizations. One study found rural residents are ten to twenty percent less likely than urban residents to receive preventative services including well-visit exams, mammograms, blood pressure checks, lipid screening, and colorectal cancer screening. Unfortunately, this failure to seek preventative care can have particularly negative consequences on higher-risk patients such as the elderly, children, and those with disabilities.  

The economics of health care and geography also serve as a significant barrier to rural residents’ access to health care as compared to their urban counterparts.

29. Id.
30. Syed et al., supra note 7, at 987.
31. Douthit et al., supra note 17, at 614.
32. Id.
33. Id.
34. Syed et al., supra note 7, at 976.
35. Thomas et al., supra note 22, at 288.
37. Syed et al., supra note 7, at 989–90.
Overall, rural areas suffer from more significant poverty than urban areas. According to one report, forty-seven percent of rural residents have family incomes of less than 200% of the federal poverty level compared with twenty-seven percent of urban families. Further, rural residents are four percent less likely than urban residents to have completed high school and eleven percent less likely to have completed college, leading to fewer job opportunities and a lower earning potential. Disparities also exist between rural and urban citizen’s insurance coverage rates and the comprehensiveness of the policies. One study looked to resident’s vision coverage to assess the comprehensiveness of insurance policies in rural Arkansas. The study discovered that because rural residents had less comprehensive coverage, they were less likely to seek and receive eyecare to avoid paying out-of-pocket expenses. Accordingly, the fact that rural populations are poorer, earn less, and work in industries with lower levels of employer-sponsored health insurance all conspire to erect barriers to health care access.

The lack of access to health care is more acute in the nation’s rural areas. From chronic shortages of health care professionals, the geographic distribution of health care facilities, services, and providers favoring urban areas, to the increased rates of poverty, and less comprehensive insurance plans, there are a multitude of factors that combine to negatively impact access to health care for many of the nation’s rural residents.

38. Valet et al., supra note 36, at 1220.
39. Id.
40. Douthit et al., supra note 17, at 615.
41. Id.
42. Id.
43. Id. at 616.
44. See generally supra Section I(b). To make matters worse, the annual rates of rural hospital closures due to poor financial performance have been steadily increasing since 2010. George M. Holmes et al., Predicting Financial Distress and Closure in Rural Hospitals, 33 J. RURAL HEALTH 239, 239 (2017). Between 2010 and 2015, sixty three rural hospitals closed due to poor financial performance, placing over 1.7 million people at a greater risk of negative health outcomes and economic hardship because of the loss of local, acute care services. Id. As a result, the closure of rural hospitals further exacerbates access to health care for the residents of rural communities who are typically poorer, older, and in worse health than their urban counterparts. Id.
C. Health Care Access Issues in Idaho

Although Idaho is consistently ranked as one of the fastest growing states in the country, it is a rural state. 45 While Idaho’s landmass of just over 82,600 square miles makes it the eleventh largest state in the union by acreage, Idaho’s population, spread out over its vast and rugged landscape, ranks fortieth among the states. 46 Further, with approximately nineteen people per square mile, Idaho ranks forty-fourth in population density. 47 This is compared to the national average population density of 87.4 people per square mile—a nearly four-fold greater population density than Idaho. 48 Eighty-eight percent of Idaho’s land area is in counties that are classified as rural with twenty-eight percent of the state’s total population housed within those rural counties. 49 Of Idaho’s forty-four counties, thirty-five are classified as rural as defined by the Idaho Department of Commerce, with nineteen of those rural counties classified as “frontier,” meaning each has fewer than six people per square mile. 50 Conversely, nationwide, only twenty percent of the population lives in rural areas. 51 These factors combine to create problems of distance and isolation from health care services for many of Idaho’s rural residents. 52 For example, one study analyzing Idaho resident distance to tertiary health care facilities—those facilities which offer treatment of complex or serious conditions by highly specialized staff—found that an average metropolitan Idaho resident lived 13.2 miles away from a tertiary health care facility while the average non-metro resident lived 65.7 miles away from a tertiary health care facility, a distance five times farther away than their urban counterparts. 53 Further, fifty percent of non-metro residents are more than sixty-six miles away from the nearest tertiary center and twenty-five percent of non-metro residents are more

46. Wolkenhauer, supra note 45, at 6.  
49. Wolkenhauer, supra note 45, at 6.  
51. Wolkenhauer, supra note 45, at 6.  
53. Id. at 11. Tertiary care is specialized medical care delivered in a hospital or similar setting. Tertiary Care, Definitive Healthcare, https://www.definitivehc.com/resources/glossary/tertiary-care (last visited Mar. 21, 2023). Tertiary care generally requires a referral from a primary care provider and is typically only available at specialized medical centers. Id.
than ninety-five miles away from the nearest tertiary center.\textsuperscript{54} This is because all five of the tertiary health care facilities in Idaho are located in an urban locale: two in the Boise area, one in Coeur d’Alene, one in Idaho Falls, and one in Pocatello.\textsuperscript{55} Apart from the urban tertiary health care facilities that rural residents must traverse to when seeking specialized care, the servicing of the health care needs of Idaho’s rural population falls to the state’s twenty-seven critical access hospitals, thirty-seven provider-based rural health clinics, eleven independent rural health clinics, and fifteen registered free medical clinics.\textsuperscript{56} This presents unique geographic challenges for rural residents seeking care for complex, serious, or chronic health conditions.

Beyond the geographic barriers to health care services for rural Idahoans, there is also a chronic shortage of health care providers in Idaho.\textsuperscript{57} According to the Idaho Department of Health and Welfare, Idaho ranks forty-fifth in the United States for active primary care physicians per 100,000 residents and forty-ninth for active physicians per 100,000 residents.\textsuperscript{58} These provider shortages are also reflected in the U.S. Department of Health and Human Services, Health Resources and Services Administration’s designation of Health Professional Shortage Areas.\textsuperscript{59} Health Professional Shortage designations are used primarily to establish eligibility for numerous federal programs and resources that are available to primary care providers to attract providers to underserved areas, but also provide the most

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\textsuperscript{54} Id.
\textsuperscript{55} Id. at 9–10.
\textsuperscript{56} Rural Health and Underserved Areas, Idaho Dep’t of Health & Welfare, https://healthandwelfare.idaho.gov/providers/rural-health-and-underserved-areas/rural-health-and-underserved-areas (last visited Jan. 8, 2022). This is not to underemphasize the critical work done by Idaho’s Community Health Centers (CHCs), including Federally Qualified Health Centers (FQHCs), for Idaho’s rural residents. Idaho’s CHCs provide primary medical, dental, and behavioral health services, to patients, both in person and via telehealth. Idaho Community Health Ctr. Assoc., Community Health Center Network of Idaho, https://www.idahochc.org/community-health-center-network-of-idaho5. According to the Community Health Center Network of Idaho, Idaho’s CHCs served 231,185 patients in 2021. Id. This amounts to one in ten Idahoans receiving healthcare from CHCs, who offer a statewide reach of 192 clinic sites in 67 communities, including 90 school-based clinics. Id.


\textsuperscript{59} Health Workforce Shortage Areas, HEALTH RES. & SERV. ADMIN. DATA WAREHOUSE (last visited Jan. 8, 2022), https://data.hrsa.gov/topics/health-workforce/shortage-areas.
accurate time-series data gathered directly from health care providers regarding staffing and capabilities of facilities.⁶⁰

A Health Professional Shortage Area can comprise a geographic area (Geographic Health Professional Shortage Area), a population (Medically Underserved Area or Medically Underserved Population), and/or a health care facility (Facility Health Professional Shortage Area) that have too few primary care, dental, or mental health providers and/or services.⁶¹ In Idaho, there are 269 Health Professional Shortage Areas, of which ninety-seven percent are deficient in primary care services, ninety-four percent are deficient in dental health services, and one-hundred percent are deficient in mental health services.⁶² Further, there are 168 Facility Health Professional Shortage Area designations across Idaho with fifty-six facilities designated as having a shortage in primary medical care, fifty-five designations for facilities with a shortage of dental services, and fifty-seven designations for facilities with a shortage in mental health services.⁶³ Additionally, according to the Health Resources and Services Administration, in Idaho there are fifty-three medically underserved areas, defined as areas with a shortage of primary care health services which cover 62.6% of the state’s land area.⁶⁴ There are also ten Medically Underserved Population designations in Idaho covering a total of 24.27% of the state’s land area.⁶⁵

Along with a scarce practitioner workforce, factors of terrain, rurality, weather, and lack of economic resources further combine to hinder rural Idahoan’s access to proper medical care.⁶⁶ As evidenced by the lack of tertiary care facilities proximate to rural Idahoans, rural residents must sometimes travel great distances or out of state to obtain care to address their health needs.⁶⁷ This can present unique challenges given the unpredictable mountain weather and nature of driving in Idaho. For instance, more than fifteen percent of Idaho roadways have a grade between five and ten percent and over twenty-four percent of Idaho roadways have grades exceeding ten percent.⁶⁸ These terrain features and roadway conditions contribute not only to traffic fatalities and accidents, but also negatively impact emergency response times and patient travel to health care facilities.⁶⁹

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60. Id.; What is Shortage Designation, HEALTH RES. & SERV. ADMIN. HEALTH WORKFORCE (last visited Apr. 27, 2023), https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation.
61. HEALTH RES. & SERV. ADMIN. DATA WAREHOUSE, supra note 59.
62. Id.
64. Id.; Health Res. & Serv. Admin. Data Warehouse, supra note 59.
65. Idaho Dep’t of Health & Welfare, supra note 47, at 27.
66. Id. at 18.
67. Id.; Beedasy, supra note 52, at 11.
68. Idaho Dep’t of Health & Welfare, supra note 47, at 14.
69. Id.
While numerous steps have been taken to increase the number of providers serving rural areas, including membership in physician and nursing licensure compacts and the establishment of the “Washington, Wyoming, Alaska, Montana, and Idaho” (WWAMI) admissions program at the University of Washington School of Medicine (where WWAMI-enrolled students attend medical school), more work is needed to increase access to care. For example, under the WWAMI program, students from the partner states who are likely to return to practice in medically underserved areas in their home states are recruited by the University of Washington School of Medicine. Although the program has made significant strides in increasing the number of rural providers, among the five states in the compact, only Washington has achieved the national mean of providers per 100,000 residents. Accordingly, there is still work to be done to continue to improve access to health care services for all Idahoans.

II. COVID-19 PANDEMIC

A. COVID-19 Pandemic Generally

On December 31, 2019 the World Health Organization (WHO) was officially notified of “a cluster of cases of pneumonia in Wuhan City,” a city of 11 million

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70. See infra note 86; see also infra note 89.

71. WWAMI, UW Med., https://www.uwmedicine.org/school-of-medicine/md-program/wwami (last visited Oct. 11, 2022). WWAMI is “a partnership with the University of Washington School of Medicine to provide medical education to students from the states of Washington, Wyoming, Alaska, Montana, and Idaho.” What is WWAMI, SOUTHWEST IDAHO AHEC, https://www.idahoahec.org/students/what-is-wwami/ (last visited Oct. 11, 2022). Idaho WWAMI started the TRUST (Targeted Rural Underserved Track) Program in 2013 which admits students with a specific interest in rural and underserved care. Id. Students admitted to the TRUST program are matched to a continuity community where the student participates in specified curricular activities across four years of medical school. Id. There are six continuity communities in rural locales: Hailey, Jerome, McCall, Nampa, Orofino, and Sandpoint. Id. Since 1972, Idaho WWAMI has graduated 578 students, with 51% returning to practice medicine in Idaho—significantly above the national average of 39%. WWAMI at the University of Idaho, IDAHO WWAMI, UNIV. OF IDAHO, https://www.uidaho.edu/academics/wwami (last visited Oct. 11, 2022).


74. See discussion supra note 1.
people and the cultural hub of central China. By January 5, 2020, fifty-nine cases were known. On January 7, 2020, Chinese scientists isolated the virus responsible and subsequently shared its genome three days later. By the 15th of January, the "WHO was aware of 282 confirmed cases" with four in Japan, South Korea, and Thailand. "There had been six deaths in Wuhan, [fifty one] people were severely ill and [twelve] were in critical condition." The global SARS-CoV-2 pandemic had begun.

On January 20, 2020, the U.S. Centers for Disease Control (CDC) announced the first laboratory-confirmed case of COVID-19 in the United States from samples taken on January 18, 2020, in Washington state. By March 11, 2020, the WHO had declared COVID-19 a pandemic and on March 13, 2020, then-President Donald Trump declared a nationwide emergency in the United States. The rest, as they say, is history, albeit history that is being rewritten daily; as of January 10, 2022, there have been at least 311,201,888 recorded cases of COVID-19 globally with at least 5,512,851 recorded deaths attributed to COVID-19 and at least 260,778,913 recoveries. In that same time frame, in the United States, there have been at least 62,661,272 recorded cases of COVID-19 with at least 861,336 recorded deaths attributed to COVID-19 and at least 42,505,374 recoveries. Currently, in the face of the COVID-19 Omicron variant and the still-circulating COVID-19 Delta variant, case positivity figures continue their meteoric ascent.

B. COVID-19 in Idaho

While COVID-19 positivity rates began to climb in the United States, many states, including Idaho, began working quickly to leverage existing assets against

76. Id.
78. Chaplin, supra note 75, at 23.
79. Id.
80. CDC MUSEUM, supra note 77.
81. Id.
83. Id.
the ever-growing pandemic. Long before the onset of the COVID-19 pandemic, however, Idaho had taken proactive steps to enable medical professionals to better respond to medical disasters and emergencies. For example, Idaho was one of thirty-two states with statutes already in effect granting licensure for volunteer physicians. Further, Idaho was one of thirty-six states offering physician licensure through direct reciprocity by way of its participation in the Interstate Medical Licensure Compact (IMLC). The IMLC offers an expedited pathway to licensure for qualified physicians seeking to practice in multiple states. Similarly, Idaho is also a member of the Nurse Licensure Compact (NLC), which allows nurses who reside and hold a multi-state license in a compact state to practice nursing in any of the other thirty-eight NLC states without having to hold additional licenses. Furthermore, before the onset of the COVID-19 pandemic, Idaho had already recognized the potential for telehealth to increase access to health care services generally. The Idaho Telehealth Council was established in 2014 and tasked with the successful development of the Idaho Telehealth Access Act in 2015, which was signed into law the same year, allowing for the provision of health care services via telehealth by licensed providers. Subsequently, in 2015 and 2018, the Idaho Department of Health and Welfare organized a series of telehealth strategic planning meetings to identify and document “existing gaps, challenges, and solutions to increasing access to telehealth” and, in 2019, presented historical telehealth planning efforts and challenges to the Health Quality Planning Commission (HQPC) who ultimately agreed that expanding telehealth in Idaho “has the potential to mitigate provider shortage challenges across the state, address rural and frontier isolation, and improve healthcare access for all Idahoans.”

85. See discussion infra Section II(b).
88. IMLC, supra note 87.
91. Final Telehealth Task Force, supra note 90, at 6–7. As a result, the HQPC endorsed the formation of the Idaho Telehealth Task Force which was tasked with “identifying the drivers and
Because issues surrounding licensure and telehealth are critical with respect to the ability to rapidly respond during medical disasters and emergencies, Idaho was well-positioned from a physician and nursing licensing standpoint to respond to a medical disaster or emergency. However, while having a policy of accelerated licensure provided a strong foundation to increase the rapidity and magnitude of provider response to medical emergencies such as COVID-19, the serious and evolving nature of the COVID-19 pandemic necessitated a more robust response.

On March 13, 2020, the same day that then-President Donald Trump declared a nationwide emergency in the United States as a result of the COVID-19 pandemic and the same day the first lab-confirmed case of COVID-19 was identified in southwest Idaho, Governor Brad Little issued a gubernatorial proclamation declaring an emergency regarding COVID-19. Governor Little’s proclamation not only authorized the plans and procedures of the State of Idaho Emergency Operations Plan to be implemented, but also directed state licensing agencies and departments to temporarily exercise enforcement discretion, implement temporary rules, and waive licensing and related requirements to maximize access to health care services and provider support in response to the growing COVID-19 pandemic. Following Governor Little’s March 13 proclamation, administrative agencies in Idaho, including the Idaho Board of Medicine and the Idaho Board of Nursing, were empowered to remove certain regulatory barriers to allow health care providers more flexibility in providing and coordinating care for patients while continuing to protect the public. Being empowered to recommend regulatory changes to increase access, the Idaho Board of Nursing recommended the suspension of numerous administrative rules and the fast-tracking of other licensure requirements such as the provision of temporary licenses to nurses from non-compact states, waiver of licensing fees, provision of temporary licenses to licensed Idaho nurses who had retired or allowed their licenses to lapse, and the opportunities to improve telehealth services adoption and expansion in Idaho for providers, clinics, specialists, hospitals, and other health system partners and recommend[ing] mitigation strategies to increase [telehealth] adoption and utilization.”


93. FIRST PROCLAMATION, supra note 92.

provision of free temporary apprenticeship certificates to students recommended by nursing schools.\textsuperscript{95} Likewise, the Idaho State Board of Medicine, which licenses and regulates doctors, physician assistants, respiratory therapists, and other health professionals recommended several changes to administrative regulations in an effort to reduce regulatory barriers and provide health care providers added flexibility in providing and coordinating patient care while continuing to protect the health and safety of the public.\textsuperscript{96} Specifically, the Idaho State Board of Medicine recommended the acceleration of the temporary licensing of medical providers who, within the previous five years, carried Idaho licenses but retired or allowed their license to lapse. The Board of Medicine further recommended the provision of temporary licenses to providers who carry a license in good standing in any other state to allow for those providers to provide patient care either in person or via telehealth, the minimization of processes for supervising physicians and their assigned physician assistants, and an increase in the number of physician assistants a particular physician is allowed to supervise.\textsuperscript{97}

By March 23, 2020, five cases of COVID-19 had been lab-confirmed in southwest Idaho.\textsuperscript{98} Continuing the rapid response to the growing pandemic, Governor Little issued a proclamation exercising authority pursuant to Idaho Code authorizing the Governor to suspend provisions of regulations that “would in any way prevent, hinder, or delay necessary action” in coping with an ongoing emergency and suspended 122 Idaho Administrative Code regulations including ninety seven Department of Health and Welfare administrative rules, seventeen Board of Medicine administrative rules, six Board of Nursing administrative rules, one Board of Pharmacy administrative rule, and one Board of Dentistry administrative rule.\textsuperscript{99}

As the pandemic continued to increase in severity, the governor’s office and numerous other state agencies continued to assess and react to the ever-changing circumstances. On March 25, 2020, after 136 cases of COVID-19 had been confirmed in Idaho, Governor Little issued a proclamation declaring a state of

\textsuperscript{95} Day, supra note 94.

\textsuperscript{96} Id.

\textsuperscript{97} Id.


\textsuperscript{99} Idaho Code § 46-1008(5)(A) (2022); Off. of the Governor, Governor Brad Little, Proclamation (Mar. 23, 2020) [hereinafter Second Proclamation].
“extreme emergency” in Idaho. This proclamation established a “Coronavirus Working Group” to aid in the public health aspects of the pandemic and to communicate to the governor’s office and the State of Idaho the “best available science, data, methods, and advice on responding to COVID-19.” On April 2, 2020, with 894 confirmed cases of COVID-19 in Idaho, another proclamation was issued renewing the suspension of the administrative regulations previously suspended on March 23, 2020, in addition to suspending eighteen additional regulations “in order to more quickly efficiently, and safely respond to the declared emergency.”

III. CHANGES TO IDAHO’S HEALTH CARE SYSTEM IN RESPONSE TO THE COVID-19 PANDEMIC

A. Telemedicine & Licensing

In considering steps that could be taken to address the growing pandemic, the Idaho Board of Medicine recognized the potential positive impact of the expansion of telemedicine. For instance, the suspended provisions enumerated in the April 2, 2020 proclamation included, pursuant to the recommendation by the Idaho State Board of Medicine, suspension of administrative regulations surrounding the practice of telemedicine in Idaho. Specifically, in the context of telehealth, the April 2 proclamation suspended the requirement set forth in Idaho Code section 54-5705 that a patient-provider relationship, in a telemedicine setting and not previously established, could only be established by use of a two-way audio-visual interaction. This suspension gave providers more freedom to use online platforms such as Zoom, Facetime, and other applications to connect with patients and provided the ability to establish the patient-provider relationship with nothing


101. THIRD PROCLAMATION, supra note 100.


103. OFF. of the Governor, Governor Brad Little, Proclamation (Apr. 2, 2020) [hereinafter Fourth Proclamation].

104. See discussion supra note 1.

105. FOURTH PROCLAMATION, supra note 103; see IDAHO ADMIN. CODE r.24.33.03.202 (2020).

106. Id.; IDAHO CODE § 54-5705 (2020).
more than a two-way audio connection or, in other words, a phone call.\textsuperscript{107} Importantly, in addition to providing more flexibility for patients and providers, this action allowed for the establishment of a patient-provider relationship when the patient or provider would not have the bandwidth or technology available to support an audio-visual connection.\textsuperscript{108}

Additionally, portions of the Idaho Code and Idaho Administrative Code relating to medical licensure requirements of licensed out-of-state providers were suspended by the April 2 proclamation. This allowed out-of-state providers holding a non-Idaho medical license in good standing and acting in good faith to provide telehealth services into or from Idaho. This served to remove barriers to out-of-state providers treating Idaho patients via telehealth technology by suspending the requirement that a provider first obtain an Idaho medical license before being permitted to legally render medical services to an Idaho patient.\textsuperscript{109}

B. Physician Assistant Supervision Limits

Governor Little’s April 2 proclamation also served to suspend administrative regulations limiting the number of physician assistants permitted to be supervised by one physician.\textsuperscript{110} Before the pandemic, Idaho Code section 54-1807A limited the number of physician assistants that one licensed physician was permitted to supervise to four. The suspension of this provision served to allow physicians to supervise more than four physician assistants, thus allowing more advanced practice providers to care for patients under the purview of one supervising physician than was permitted before the onset of the COVID-19 pandemic.\textsuperscript{111}

Because the emergency declarations were statutorily limited to thirty-day periods, proclamations extending the declared state of emergency and extending the previously suspended administrative regulations were issued again on May 12,
On June 22, 2020, Governor Little issued Executive Order 2020-13, stating that in response to the COVID-19 pandemic, various Idaho state agencies had recommended the suspension of over 150 regulations in an effort to “move more quickly, efficiently, and safely” to respond to the declared emergency and that “if waiving these regulations was deemed necessary to improve public health and welfare during the declared emergency . . . the regulations are unnecessary or counterproductive outside of the declared emergency.”

Therefore, all regulations that were listed in the emergency proclamation of June 11, 2020 and any other regulations “waived, suspended, or otherwise altered by state agencies” were permanently suspended so long as they were found by the appropriate administrative agency to not be required by law to remain in place or the permanent suspension of the regulation to be deleterious to public health or safety. Accordingly, pursuant to the procedures set forth in Executive Order 2020-13, the Board of Medicine, the Board of Nursing, the Department of Health and Welfare, the Idaho State Board of Dentistry, the Division of Occupational and Professional Licenses, and the Board of Pharmacy moved to permanently suspend the administrative regulations previously only temporarily suspended in response to the COVID-19 pandemic. Not only did the permanent suspension of these administrative regulations allow agencies to move more quickly, efficiently, and safely to respond to the declared emergency and adhere to Governor Little’s stated policy goal of deregulation, more importantly and timely, they had the effect of increasing access to health care during the worst pandemic in 100 years.

112.  **IDAHO CODE § 46-1008(2)** (2020); Off. of the Governor, Governor Brad Little, Proclamation (May 12, 2020) [hereinafter Fifth Proclamation].
113.  Off. of the Governor, Governor Brad Little, Proclamation (June 11, 2020) [hereinafter Sixth Proclamation].
115.  **SIXTH PROCLAMATION, supra note 113.**
117.  **Id. at 129.**
118.  **Id. at 131.**
119.  **Id. at 32.**
120.  **Id. at 127.**
121.  **20-7 Idaho Admin. Bull. 133** (July 1, 2020).
122.  **Id. at 538.**
123.  **Id. at 24.**
124.  Wicklund, **supra note 107.**
C. Crisis Standards of Care

Anticipating a potential overwhelming of the health system brought on by the COVID-19 public health emergency, the Idaho Department of Health and Welfare (DHW) partnered with local public health, emergency management, emergency medical services, and health care and legal partners across the state to develop the Idaho Crisis Standards of Care (CSC) Plan. The CSC Plan provides a framework for Idaho to adopt CSC, provides guidance for health care entities during catastrophic public health care emergencies or disasters that have the effect of overwhelming available health care assets, and supports the coordination of public health, emergency management and medical services, and health care organizations throughout Idaho. Additionally, the CSC Plan provides a framework to activate CSC during disaster situations during which the usual standards of care are unable to be met due to the depletion of existing health care resources. CSC serve to provide an assist when the untenable decision making processes arise on account of demand for care outstripping supply. To do so, the CSC Plan provides "guidelines that help healthcare providers and systems decide how to deliver the best care possible under the extraordinary circumstances of an overwhelming disaster or public health emergency." The stated goal of CSC is to, as a last resort, provide "care to as many patients as possible and save as many lives as possible" when existing health care infrastructure is overwhelmed.

Crisis standards of care were first enacted in Idaho on September 6, 2021, for the Panhandle and Northern Central Health Districts after a request from Kootenai Health. Subsequently, CSC were enacted statewide on September 16, 2021 after a request by St. Luke’s Health System (SLHS), indicating that the surge of COVID-19 patients had "exhausted the supply of staff, available beds and necessary resources to adequately address the demands for health care services." On November 22, 2021, CSC were deactivated for all public health districts, except for

125. See generally Coordinated Consulting Servs., Idaho Dep’t of Health & Welfare, Crisis Standards of Care 7–8 (2020); see also Idaho Admin. Code r.16.02.09 (2021).
126. See COORDINATED CONSULTING SERVS., supra note 125, at 7–8.
127. See id.
129. Id.
130. Idaho Dep’t of Health & Welfare, Declaration of Crisis Standards of Care (Sept. 6, 2021).
132. Id.
the panhandle district, which was later deactivated until December 20, 2021. Unfortunately, CSC did not remain idle for long as a reactivation was necessary for Public Health Districts three, four, and five on January 24, 2022, pursuant to a request by Saint Alphonsus hospital system indicating that severe resource shortages would not allow the system to meet the unprecedented patient demand. Crisis standards of care remain in effect for those health districts encompassing southwest, central, and southwest central Idaho due to COVID-19 positivity rising to unprecedented levels. Apart from prioritizing resources when the need for care exceeds available supply, the enactment of CSC serves to limit provider malpractice liability when a scarcity of resources prevents providers from meeting the usual standard of care. This has the practical effect of improving access to care by providing implicit assurances to providers that their malpractice liability is limited when there are insufficient resources to meet the overwhelming demand for care. As such, providers who may be apprehensive to practice while CSC is enacted due to fears of potential malpractice liability can be assured that their malpractice liability is limited.

IV. IMPACT OF IDAHO’S COVID-19 RESPONSE ON ACCESS TO CARE

A. Licensing Impacts

The actions taken by the Idaho governor’s office and administrative agencies in response to the COVID-19 pandemic have proven to have a positive effect on overall access to health care in Idaho. Actions taken by state licensing boards, such as making it easier for retired doctors, nurses, respiratory therapists, and pharmacists to temporarily reactive their expired licenses, has allowed health care professionals with lapsed licenses to heed the calls for help. For instance, between the Idaho Board of Nursing starting the temporary recertification process

135. Id.
137. See discussion supra note 1.
in April 2020 and August 27, 2021, the Board of Nursing processed over 1,000 licensees who had previously retired or otherwise allowed their licenses to lapse. Although many of these newly re-licensed providers likely did not step immediately into a COVID-19 ward, easing the re-licensure process allowed previously licensed providers to quickly “fill another role in the hospital that frees up dedicated staff . . . need[ed] to care for ICU patients, COVID patients, and other patients . . . that need care.” Likewise, although the Board of Medicine is no longer issuing new temporary licenses to retired and inactive practitioners for COVID-19 purposes, those efforts and others taken to ease licensure have nonetheless had a positive effect on overall access to health services when the health system was significantly burdened.

B. Telehealth Impacts

In addition to easing certain medical licensure requirements, Idaho’s changes to regulations surrounding telemedicine have also had a positive effect on overall access to health care by increasing the capacity of Idaho’s health care system. For example, during the three months spanning March, April, and May 2019 there were 3,000 telehealth sessions in Idaho. Comparatively, after the onset of the COVID-19 pandemic in March 2020 and the subsequent suspension of regulations surrounding the provision of telehealth services, there were 117,000 telehealth sessions in Idaho during that same March-to-April span in 2020—a 3,800% increase. Similarly, in April 2019, only thirty-four Idaho Medicaid behavioral health providers reported using telehealth. By April 2020, 1,069 Idaho Medicaid behavioral health providers were using telehealth to provide medical services to patients in Idaho—a 3,044% increase. Likewise, 206 patients reported receiving

139. Id.
140. Id.
142. Wicklund, supra note 107.
143. Id. According to the Idaho Department of Insurance, in March-July 2020 as compared to the same period in 2019, telehealth behavioral health visits increased 32,059% and telehealth medical visits increased 12,681% for an overall increase of 17,075%. IDAHO DEP’T OF HEALTH & WELFARE, DIV. PUB. HEALTH TELEHEALTH BRIEF, 2 (2021). The Centers for Medicare and Medicaid Services (CMS) also reported similar increases nationally—from 13,000 telehealth visits to 1.7 million telehealth visits per week. Id.
145. Id.
Medicaid behavioral health services via telehealth in April 2019 compared with 15,406 in April 2020—a 7,379% increase.\textsuperscript{146} Because telehealth services can be provided and accessed from anywhere so long as both the provider and the patient have an internet or cellular data connected-device, the newfound ability of medical providers across the country to offer telehealth services in Idaho helped to address the critical shortage of medical providers in every county in the state.\textsuperscript{147}

C. Physician Assistant Oversight Impacts

Beyond changes to regulations surrounding the provision of telehealth services, changes to laws surrounding physician assistant supervision and collaboration have also positively impacted access to health care in Idaho. After regulations enumerated in Idaho Code section 54-1807A surrounding physician assistants were permanently suspended for the duration of the public health emergency brought about by the COVID-19 pandemic by Governor Little’s April 2 proclamation, the Idaho legislature adopted permanent changes to Idaho Code section 54-1807A in the first legislative session of 2021 with the aim of improving access to care in rural and underserved areas.\textsuperscript{148} To effectuate that goal, the new statute provided for more generalized oversight of physician assistants and reduced the regulatory and administrative burdens on physician assistants, physicians, hospitals, and other organizations.\textsuperscript{149} Among other things, the new law jettisoned the requirement for individually identified supervising physicians and their delegation of services agreements for general oversight provisions focusing on collaboration and corresponding collaborative practice agreements.\textsuperscript{150} Additionally, significant to access, the new statute and the corresponding regulations promulgated by the Board of Medicine removed provisions that required supervising physicians to perform such tasks like periodic review of medical records and regular meetings with physician assistants under their supervision.\textsuperscript{151} Moreover, it removed much-maligned provisions that rendered a supervising physician vicariously liable for the actions of the physician assistant.\textsuperscript{152} While physicians and organizations are free to continue under the previous structure of individualized supervision of physician assistants and delegation of services

\textsuperscript{146} Id.
\textsuperscript{147} See Wicklund, supra note 107.
\textsuperscript{149} S.B. 1126 (Idaho); Stanger, supra note 148; see SUMMER 2021 REPORT, supra note 141.
\textsuperscript{150} Stanger, supra note 148.
\textsuperscript{151} Id.
\textsuperscript{152} Id.
agreements, under the new statutory scheme, they are no longer required to do so. With these arguably bothersome provisions removed, collaborating physicians and organizations are rendered more likely to take on additional collaborations with physician assistants; thus increasing the overall bandwidth of the healthcare system and, in turn, increasing baseline health care access.

D. Provider Discipline Impacts & Patient Safety Concerns

While Idaho’s loosening of health care regulations in March 2020 may be cause for concern that deregulation in this area can lead to worse patient outcomes and increased instances of health care provider discipline, data from the Idaho Board of Medicine and Board of Nursing is not definitive on that point. An assessment of disciplinary actions taken by the Board of Medicine shows that from 2018–2019 there were forty-four disciplinary “board actions” ranging from stipulation and order agreements, public reprimands, fines, license suspensions, conditional license reinstatements, and license revocations. Conversely, for the same period ranging from 2020–2022, there have been twenty-four disciplinary actions taken by the board—a 45% decline. However, this data does not capture the entire picture of poor patient outcomes as reflected in adverse board actions as final resolution of complaints because the Board’s announcement, if any, of disciplinary action can take several months. For this reason, looking to complaints received by the Board of Medicine during the same timeframe presents a more accurate depiction of potential adverse patient outcomes resulting from deregulation during the pandemic. From 2018–2019 the Board of Medicine

153. Id.


received 521 complaints.\textsuperscript{157} Comparatively, from 2020–2021, 666 complaints were received by the Board of Medicine—a 28% increase.\textsuperscript{158}

Data from the Idaho Board of Nursing reveals a similar pattern. Between January 2018 and January 2020 there were forty disciplinary “board actions” ranging from license revocation, conditional license reinstatement, suspension, voluntary surrender, and denial of license renewal.\textsuperscript{159} Comparatively, for the period between February 2020 and November 2021, there were nineteen disciplinary “board actions”—a 53% decrease.\textsuperscript{160} However, looking to complaints filed with the Board of Nursing during that timeframe, an increase similar to the Board of Medicine is noted. From 2018–2019 there were 385 complaints filed with the Board of Nursing.\textsuperscript{161} Comparatively, from 2020–2021, there were 970 complaints filed—a 151% increase.\textsuperscript{162}

While complaints to the Board of Medicine and Board of Nursing increased during the two years of the COVID-19 pandemic as compared with the preceding two years, the increase occurred against the backdrop of a record number of provider-patient interactions and unprecedented stress on the state’s health care providers and systems.\textsuperscript{163} Although it is unclear if the rise in complaints resulted from the increase in health care utilization necessitated by the pandemic, from more providers practicing within the state than before, or from a combination of both, it is clear that board complaints increased alongside access-increasing deregulation. These causal waters are further muddied when considering that non-emergency procedures were suspended during pandemic surges, thus lowering the number of overall non-COVID-19 patient-provider interactions.\textsuperscript{164} However, despite the lack of evidence for direct causation, this data suggests there is both support for concerns that health care deregulation can lead to worsened patient outcomes,

\begin{itemize}
\item \textsuperscript{157} E-mail from Bob McLaughlin, Pub. Info. Officer, Idaho Div. of Occupational & Pro. Licenses Admin. Section to Christopher Kmoch, Univ. of Idaho Coll. of L. (Mar. 1, 2022, 09:07 MST) (on file with author).
\item \textsuperscript{158} Id.
\item \textsuperscript{159} Idaho Bd. of Nursing, Board Actions 1/1/2018–11/4/2021 (2021).
\item \textsuperscript{160} Id.
\item \textsuperscript{161} E-mail from Bob McLaughlin, Pub. Info. Officer, Idaho Div. of Occupational & Pro. Licenses Admin. Section to Christopher Kmoch, Univ. of Idaho Coll. of L. (Mar. 1, 2022, 09:07 MST) (on file with author).
\item \textsuperscript{162} Id.
\item \textsuperscript{163} Id.; see Wicklund, supra note 107; see also Doug Petcash, Viewpoint: Crush of COVID-19 patients puts enormous strain on Idaho hospitals, KTVB7 (Oct. 3, 2021, 8:10 PM), https://www.ktvb.com/article/news/local/viewpoint/viewpoint-covid-crush-idaho-hospitals-mortality-rate-vaccine/277-038a8945-bba0-479a-88ee-4aa977077163.
\end{itemize}
at least as reflected in board complaints, as well as support that those concerns may not be as significant as some have feared.

The steps taken to improve access to health care in light of the COVID-19 pandemic has taken on special importance as the pandemic has continued to strain health systems. During the COVID-19 surge brought on by the Omicron variant that was experienced during the summer of 2021, and at numerous other times throughout the pandemic, health systems have struggled with staffing shortages while simultaneously being faced with record numbers of patients. In response to staffing shortages and record numbers of patients, health systems have responded by asking for qualified volunteers living in the state to fill the void. Additionally, health systems and state agencies including the Idaho Department of Health and Welfare requested additional health care workers be sent to the state through the Emergency Management Assistance Compact as well as additional staff from the federal government through FEMA. While the COVID-19 pandemic has burdened health systems in Idaho in an unprecedented manner, Idaho’s deregulation in response to COVID-19 has positioned the state to allow as many providers to work within the health system as possible to meet the extraordinary challenges brought on by the COVID-19 pandemic.

However, although Idaho’s expansive approach to deregulation increased overall access to health care during the COVID-19 pandemic, the question remains: was it effective? Unfortunately, there is no clear answer. Over the course of the pandemic, at least 4,772 Idahoans have lost their lives as a result of complications brought on by COVID-19 infection. Perhaps a grim measure of “success,” this represents the 19th lowest per capita death rate in the country with 266 deaths resulting from COVID-19 per 100,000 Idaho residents. Even though there are more providers available to provide care, as a result of the unprecedented strain on health systems and corresponding resource shortages, the Idaho National Guard was activated four times over the course of the pandemic to assist with COVID-19

165. Cohen, supra note 138.
166. Id.
response efforts. In certain health districts around the state, crisis standards of care had to be activated numerous times because of continued critical overwhelming of health care infrastructure. Thousands of Idahoans needed to forego non-emergency surgeries due to the impact of COVID-19 on health systems. Further, despite such grave losses, Idaho remains one of the lowest vaccinated states in the country with only 55.1% of the population fully vaccinated against COVID-19. Although low rates of infection and death, the extent of adverse economic impacts, and vaccination rates are seen by some to be the best barometer by which to measure the success of any given COVID-19 response, given the nature of the pandemic, there is no clear answer as to whether Idaho’s response to COVID-19 was as effective as possible. Despite this critical question remaining unanswered, important lessons can still be gleaned from Idaho’s COVID-19 response to not only inform preparedness for future pandemics, but to increase access to care at-large.

V. INCREASED AVAILABILITY OF TELEHEALTH CAN IMPROVE ACCESS & PATIENT OUTCOMES

A. Improving Access

Much like access to care, telemedicine encompasses many different concepts. Telemedicine is defined as the “use of electronic information and communications technologies to provide and support health care when distance separates the participants.” Analogous but broader, telehealth includes telemedicine but also other health-related services that use electronic communication technologies such as health information sharing, health professional and patient education, and remote patient monitoring. Telehealth has long held significant potential for addressing health disparities perpetuated by inadequate health care access experienced by many rural and underserved

171. See IDAHO DEPT OF HEALTH & WELFARE, supra note 128; see also IDAHO DEPT OF HEALTH & WELFARE, supra note 134.
172. See Dutton, supra note 164.
175. Marcin et al., supra note 27, at 169.
176. Id.
The implementation of telehealth programs in response to the COVID-19 pandemic has further revealed telehealth’s incredible potential for addressing rural health care disparities and barriers to access that are unique to rural and underserved communities. First, data has shown that when providers are rendered eligible to provide telehealth services without having to surmount regulatory and administrative barriers such as licensing costs, they are more likely to provide telehealth services. This is reflected in the increased number of providers offering telehealth services; in April 2021, eighty-four percent of physicians were offering virtual visits with fifty-seven percent stating they would prefer to continue offering virtual care. Because an urban provider offering telehealth services is capable of rendering care to patients regardless of their locale, rural health care access is positively impacted by this increased supply. Second, the use of outpatient telehealth visits frees up hospital beds and other resources for patients most in need, thus increasing the availability of health care infrastructure for the patients who need care most. Third, utilization of telehealth services can ease geographic burdens experienced by rural and underserved communities by allowing patients, in certain circumstances, to be seen in their own communities by medical professionals of their choosing, without needing to travel a significant distance to the nearest health care facility. Fourth, the use of telehealth can introduce otherwise unavailable specialty and subspecialty expertise into remote communities, at times reducing the need for patients to be transferred to large urban or regionalized tertiary care centers to be evaluated by specialty and subspecialty providers. Fifth, telehealth can reduce the burdens of caregivers missing work, school, and other obligations and reduce the costs and risks of travel, thus making patients more likely to seek needed care. These factors illustrate telehealth’s incredible potential to continue to positively impact health care access.

178. Id. at 1817–18.
181. See id.
182. Hoffman, supra note 179, at 1.
183. Marcin et al., supra note 27, at 169.
184. Id.
185. Id.
Although telehealth possesses enormous potential to positively impact health care access, as the pandemic has begun to wane, telehealth’s usage has plummeted. One recent study compared telehealth usage in commercial, Medicare Advantage, and Medicaid managed care claims during March to December 2020 with the same period in 2021 and discovered an average decline of 40.3% per month in usage.\(^\text{186}\) While utilization of telehealth services during the pandemic mitigated the risk of exposure to COVID-19 inherent with an in-office visit, now that positivity rates have begun to fall, many providers and patients may rather wish to see each other in-person than through a screen.\(^\text{187}\) This is likely due to the fact that the formation of a strong patient-doctor relationship, historically through in-person interactions, is seen by many to be critical to the formation of the patient-provider trust-based relationship.\(^\text{188}\) For instance, a 2012 workshop summary found that many providers participating in the workshop were reluctant to utilize telehealth, citing concerns of depersonalization and damage to trust relationships.\(^\text{189}\) Likewise, there are other considerations that may limit telehealth’s ability to positively impact access to care, such as the lack of the ability to pay for telehealth services and the lack of technology access.\(^\text{190}\) Further, the use and reliance on technology can exacerbate disparities in health care access for vulnerable populations including racial and ethnic minorities, non-English speakers, and the elderly.\(^\text{191}\)

B. Improving Patient Outcomes

Telehealth has a positive impact on rural health care access beyond removing barriers to access. While telehealth is commonly conceptualized as simply a “virtual visit” between a doctor and a patient, the concept of telehealth is not limited to provider-to-patient interactions. For example, the Extension for Community Healthcare Outcomes (Project ECHO) works to train and educate remote providers—often rural nurse practitioners and medical assistants—on specialized


\[^{187}\] See Bestsennyy, supra note 180.


\[^{189}\] Id.


To accomplish their goal, volunteer project ECHO medical specialists hold no-cost video conferences to present challenging patient cases to groups of rural providers which provides an opportunity to “ask questions and get advice on care.” Project ECHO’s “work fills what experts see as a gaping need for specialty care in remote communities” by providing specialized training and consultation services to rural providers. Although not within the commonly conceptualized patient-provider context of telehealth, project ECHO’s “tele-mentoring” gives rural providers skills needed to treat scores of patients, and thus has immense potential to have a positive impact on health care access and patient outcomes in the communities in which the recipients of project ECHO’s efforts work.

Although there is significant potential for telehealth to improve patient outcomes, there are also risks. One such risk is that of fragmenting care. Fragmented care occurs when a patient seeks care from multiple providers who are unable to communicate with one another as to what care is being provided. Fragmented care can lead to gaps in care, overuse of medical care, inappropriate use of medications, and the provision of unnecessary care. Further, due to the limitations inherent in virtual settings, there is the risk of misdiagnosis or delayed diagnosis due to fragmented care. Because telehealth “cannot change the way some care must be delivered,” providers may miss nuanced issues that would otherwise be identified in an in-person setting, such as signs of drug or alcohol abuse. This was reflected in a recent study in which only fifty percent of primary care providers surveyed were confident they could identify signs of patient drug abuse via telehealth interactions as compared with ninety-one percent of providers that indicated they were confident they could identify the signs in an in-person setting. These risks may have the effect of discouraging some providers from

193. Id.
194. Id.; Marcin et al., supra note 27, at 171.
195. Brodwin, supra note 192.
198. Id.; See also MAYO CLINIC, supra note 190.
199. Klein, supra note 196.
200. Id.
201. Id.
offering telehealth services due to the risk of missed diagnoses and patient expectations of telehealth services being commensurate with in-person visits. Nonetheless, telehealth possesses massive potential to both increase access to health care as well as improve patient outcomes.

VI. BARRIERS TO MAINTAINING INCREASED ACCESS TO CARE THROUGH TELEHEALTH IN IDAHO

A. Technological Barriers

While telehealth has had a positive impact on health care access for rural and underserved communities generally, issues endemic to rural and underserved communities remain a barrier to health care access in the telehealth context. Namely, utilization of telehealth services requires adequate broadband or cellular data access, which is often limited, sporadic, or nonexistent in rural areas. In fact, research shows that approximately thirty-three percent of rural Americans lack broadband internet with download speeds sufficient to support video-based telehealth visits, defined by the Federal Communications Commission as twenty-five megabits per second. Without access to technology capable of supporting video-based telehealth visits, residents of these digitally isolated regions are unable to realize the positive effects that telehealth has on health care access.

Recognizing the lack of broadband service sufficient for telehealth interactions in rural areas, Idaho suspended the requirement set forth in Idaho Code section 54-5705 that a patient-provider relationship, in a telemedicine setting and not previously established, can only be established by use of a two-way audio-visual interaction; and instead permitted a patient-provider relationship to be established via an audio connection or, in other words, a telephone call. This has served critical to the establishment of the requisite patient-provider relationship in telehealth settings for those in Idaho without the capabilities to accommodate an audio-visual connection. To illustrate the importance of allowing the patient-provider relationship to be established via an audio-only connection, between summer and fall 2020, fifty-six percent of telehealth visits in the United States involved only a telephone call between patient and provider. Although Idaho’s suspension of the audio-visual requirement did not assist individuals without access to a telephone, it nonetheless served to allow for the establishment of numerous

202. Id.
203. Hirko et al., supra note 177, at 1817.
204. Id.
206. FOURTH PROCLAMATION, supra note 103; IDAHO CODE § 54-5705 (2020).
patient-provider relationships that otherwise would not have been possible. However, because the provision of Idaho Code section 54-5705 requiring a patient-provider relationship in the context of telehealth to be established via an audio-video interaction is only suspended for the duration of the emergency brought about by COVID-19, the lack of broadband access in rural and underserved communities will again serve to limit access to telehealth services within those communities when the emergency no longer exists.

While the lack of broadband access is a barrier to the provision of telehealth services in rural areas, recent legislation suggests this barrier will not last in perpetuity. The recent enactment of the Infrastructure Investment and Jobs Act committed sixty-five billion dollars to improving broadband in rural communities, with the majority of the funding going toward creating access and improving download speed. However, there is concern surrounding how long it will take to roll out the program and provide rural areas with broadband service, in addition to concerns about implementing the program at the state and local level. Nonetheless, help is [eventually] on the way.

B. Economic Barriers

In addition to access to requisite technology, other barriers to the potential of telehealth continuing to have a positive impact on access to care include issues relating to reimbursement and licensure. Reimbursement issues serve as the most significant barriers to the continuation of telehealth services because, in order for providers to continue to offer telehealth services, there must be a sufficient economic incentives for providers to continue to offer them. Central to the issue of reimbursement is the Centers for Medicare & Medicaid Services (CMS). While in response to the COVID-19 pandemic CMS has made numerous changes to provide for greater reimbursement for Medicare patients utilizing telehealth

208. See generally OPUM, supra note 144.
212. Id.
213. Hoffman, supra note 179, at 1.
214. Id. at 4.
215. Id.
services, such as allowing providers to seek reimbursement for numerous telehealth services that were not previously eligible, more changes are needed surrounding the eligibility for certain services, reimbursement rates, and reimbursement eligibility in a post-COVID-19 world in order to ensure sufficient economic incentives for providers to continue to offer these services via telehealth.  

An encouraging sign for the continued economic viability of telehealth services is that the explosion of telehealth services during the COVID-19 pandemic has not gone unnoticed in the business community. Recognizing telehealth as a cost-saving measure for companies and their employees amidst rising health care costs, Teladoc Health, a virtual care company, has partnered with Trustmark Health Benefits to offer a virtual-first health care plan, under which patients are entitled to zero dollar co-pays for virtual services. Similarly, in October 2021, Cigna, the thirteenth largest company in the United States by revenue, announced it would be offering to select employers a virtual-first plan provided by their subsidiary, telehealth provider MDLIVE. Likewise, UnitedHealthcare, the fifth largest company in the United States by revenue, also announced a virtual-first option that is currently available to employers in nine markets. As more businesses recognize the benefits of telehealth and structure health plans around it, it is likely that telehealth will continue to have a positive impact on rural health care access for those communities in which these health plans are offered.

C. Regulatory Barriers

Another barrier to the ability of telehealth continuing to have a positive impact on access to care in Idaho surrounds physician licensure. In March 2020, Idaho suspended the requirement that a provider must be licensed in Idaho to provide telehealth services to an Idaho patient in an effort to allow providers with a license in good standing in another state to practice telehealth in Idaho without holding an Idaho medical license. While this has significantly contributed to the

216. Id. at 4–6.
220. See discussion supra note 1.
incredible increase in telehealth interactions,\textsuperscript{222} the suspension of the licensing requirement will last only as long as the state of emergency necessitated by the COVID-19 pandemic persists.\textsuperscript{223} Therefore, as soon as the state of emergency ends, a provider wishing to provide telehealth services to an Idaho patient will be required to first obtain an Idaho medical license.\textsuperscript{224} This undoubtedly will have a negative effect on access to care in Idaho by reducing the number of providers currently eligible to provide care in the state.

Highlighting this inevitable negative impact on health care access, a recent study regarding telehealth best practices evaluated the laws of each state as they relate to the provision of telehealth services.\textsuperscript{225} The study focused on the ease with which patients and providers can access and practice telehealth by focusing on whether a state permits multiple modalities for the provision of telehealth services, whether all kinds of providers can utilize telehealth, and whether across-state-lines provision of telehealth services is permitted absent an in-state license.\textsuperscript{226} While Idaho fared well in comparison to several other states, it failed to take top honors despite its extensive deregulation in response to the COVID-19 pandemic.\textsuperscript{227} This was chiefly on account of the requirement that providers be licensed in Idaho to practice telehealth in the state which, although currently suspended, will be required at the conclusion of the COVID-19-induced state of emergency.\textsuperscript{228} Presently, Arizona, Florida, and Indiana are the only states which permanently do not require in-state licensure for the provision of telehealth services.\textsuperscript{229} In lieu, each state provides a registration process that allows out-of-state providers to deliver telehealth services without obtaining a separate license for their state.\textsuperscript{230}

\textbf{VII. CONCLUSION}

In response to the COVID-19 pandemic, Idaho boldly took numerous steps to increase access to health care by providing flexibility to physicians, advanced

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  \item \textsuperscript{222} Wicklund, supra note 107.
  \item \textsuperscript{223} June 2020 Report, supra note 221, at 3; see also Idaho Div. of Occupational and Pro. Licenses, Idaho Telehealth Access Act COVID-19 Guidance (Mar. 15, 2022).
  \item \textsuperscript{226} Id.
  \item \textsuperscript{227} See id. at 21.
  \item \textsuperscript{228} Id.; June 2020 Report, supra note 221.
  \item \textsuperscript{229} Archambault & Nastasi, supra note 225, at 12, 18, 23.
  \item \textsuperscript{230} See id.
practice providers, nurses, and patients in the context of telehealth, licensure, and supervision of advanced practice providers. As illustrated through the exponential increase in the number of telehealth interactions, the issuance of thousands of temporary licenses, and the permanent enactment of regulations giving physicians and physician assistants more flexibility and autonomy in the provision of care, Idaho’s efforts to increase access to health care during the COVID-19 pandemic were largely successful in positively impacting access to care. Not only did Idahoan’s overall access to care improve, but many of the barriers to access were surmounted by Idaho’s actions in response to COVID-19. Importantly, increased access to telehealth services mitigated the geographic, terrain, and transportation barriers to care, enabled patients to seek preventative care and services tailored to their condition, and provided an avenue to address cultural barriers through increased frequency, availability, and ease of patient-provider interactions and education.

Idaho increased access to care when it was needed most. Many of Idaho’s neighbors would be wise to follow Idaho’s example and act to increase access to care for their residents. For instance, in Utah, providers cannot render telehealth services to Utah residents without first obtaining a full Utah medical license. Likewise, Nevada and Oregon allow out-of-state providers to obtain a separate telemedicine license, but the process requires time and money that many providers may not be willing to spend—especially when those requirements are not currently required to practice telehealth in Idaho. In fact, Idaho’s response to COVID-19 has gained national attention. In a report of how each state has so-far fared during the COVID-19 pandemic regarding factors including health, the economy, social well-being, and education, Idaho was tied with Utah and Maryland for second place in the United States, finishing only behind Nebraska. Unfortunately, however, this increased access to care may be fleeting. While Idaho’s regulatory changes have had the effect of increasing access to health care, only some have been permanently enacted. Accordingly, once the public health emergency declaration ends, many of these waivers and regulatory flexibilities for providers and patients, despite their demonstrated positive impact on access to care and their lack of a negative impact on provider discipline and patient outcomes, will be lost. To prevent this from happening, the Idaho legislature should permanently adopt all telehealth reforms taken in response to COVID-19 to ensure all Idahoans receive lasting access to safe and quality care.


232. Id.