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HEALTHCARE INSIGHTS

Valuation of Telemedicine: Reimbursement (Part II of V)

By Todd Zigrang, MBA, MHA, FACHE, CVA, ASA, and Jessica Bailey-Wheaton, Esq.

Telemedicine has rapidly advanced over the past couple of decades, and its advancement has been significantly accelerated since the COVID-19 pandemic struck the U.S. These virtual services have the potential to allow greater access to, and quality of, care, while also resulting in significant cost savings. However, the technology also has numerous challenges, such as infrastructure gaps, capital requirements, and knowledge barriers among patients.

This second installment of a five-part series on the valuation of telemedicine focuses on the reimbursement environment for telemedicine.[1] Telemedicine is reimbursed based on the services provided through this medium and includes many restrictions on where, how, and by whom services can be conducted.

Pre-COVID-19

Traditionally, there have been many restrictions on telemedicine service coverage. Medicare has included geographical restrictions, provider restrictions, payment limitations, facility fee limitations, and limitations on covered services in their telemedicine reimbursement regulations. For example, Medicare beneficiaries had to be located in a rural health professional shortage area (HPSA) or in a county outside of a metropolitan statistical area (MSA).[2] It was not until the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019 that the Centers for Medicare & Medicaid Services (CMS) was allowed to waive certain geographic restrictions related to the patient's location.[3] A patient's location when receiving care, called the originating site, was, until the CONNECT Act, an important factor in determining reimbursement eligibility.[4] In 2019, whether an originating site (to which Medicare pays a facility fee—$26.65 in 2019[5]) was authorized depended on the facility's geographic area.[6] States had differing rules on the patient setting, with 29 states not including patient setting as a condition for payment, 12 states recognizing school as an originating site, and 12 states recognizing the home as an originating site.[7] Medicare also restricted which practitioners could receive payments for covered telemedicine services.[8] Covered services have also traditionally been limited, although CMS has added

1 For the purposes of this series, the terms "telemedicine" and "telehealth" will be considered to be synonymous, with the former used exclusively for the sake of consistency.

2 Centers for Medicare & Medicaid Services, Medicare Learning Network, *Telehealth Services*, MLN Fact Sheet 901705, June 2021, 3, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.

3 Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2019, S. 2741, 116th Cong. (2019).

4 Centers for Medicare & Medicaid Services, Medicare Learning Network, *Telehealth Services*, MLN Fact Sheet 901705, June 2021, 3–4, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.

5 Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 84 Fed. Reg. 62,630 (November 15, 2019).

6 Authorized originating sites as of June 2021 included: physician and practitioner offices, hospitals, critical access hospitals (CAHs), rural health clinics, federally qualified health centers, hospital-based or CAH-based renal dialysis centers (including satellites), skilled nursing facilities (SNFs), community mental health centers (CMHCs), renal dialysis facilities, homes of beneficiaries with end-stage renal disease (ESRD) getting home dialysis, and mobile stroke units. Centers for Medicare & Medicaid Services, Medicare Learning Network, *Telehealth Services*, MLN Fact Sheet 901705, June 2021, 3, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.

7 Ann Mond Johnson et al., *2019 State of the States: Coverage & Reimbursement*, American Telemedicine Association, July 18, 2019, 4.

8 As of June 2021, these practitioners included physicians, nurse practitioners (NPs), physician assistants (PAs), nurse-midwives, clinical nurse specialists (CNSs), nurse anesthetists, clinical psychologists and social workers, and registered dietitians. Centers for Medicare & Medicaid Services, Medicare Learning Network, *Telehealth Services*, MLN Fact Sheet 901705, June 2021, 4, https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf.

new services to this list every year through the Medicare Physician Fee Schedule (MPFS). At the beginning of 2021, 270 telemedicine services were reimbursed by Medicare.[9]

Telemedicine's greatest appeal and promise for many is not just the ability to reach underserved populations, but to save money for both payors and patients by giving the latter a less expensive option for care than in-person or emergency room visits. However, while adoption and utilization of telemedicine have been increasing over the years, telemedicine has remained a low percentage of all healthcare visits and spending, as government reimbursement remains uncertain. Because CMS has been slow to expand telemedicine benefits, reimbursement has been trailing behind growing provider and patient interest in these services. Additionally, as with most healthcare services, private payors followed Medicare's lead on telemedicine reimbursement; consequently, even as technological capabilities have grown, telemedicine services have remained on the margins of healthcare spending and investment. By 2016, however, most private insurance carriers and self-insured employers had included telemedicine benefits in areas such as behavioral health, dermatology, radiology, infectious diseases, and stroke.[10] Around that same time, however, only 15 percent of family physician practices used telemedicine, with the majority of physicians citing a lack of reimbursement as their top reason for not integrating telemedicine into their practices.[11]

As public payors—as well as more private payors and providers—began to recognize the potential of telemedicine, adoption of this technology accelerated. As of the American Telemedicine Association's (ATA's) 2019 report on coverage and reimbursement, only 10 states had not yet enacted substantive policies for telemedicine reimbursement.[12] Additionally, 21 and 28 states, respectively, have coverage and payment parity policies related to Medicaid.[13] States more often regulate private payors: 36 states have coverage parity and 16 states have payment parity related to private payments.[14] These parity policies may provide strong incentives for physician practices to adopt telemedicine technology.[15] However, at the same time, equal payments undermine the cost-saving argument for telemedicine and create complications for technology adoption.[16]

In its 2019 report, the ATA stated that 29 states do not include patient setting as a condition for payment.[17] Further, the majority of states also recognize modalities of telemedicine delivery other than synchronous technology, with some states even allowing for audio-only visits; but 16 states still limit telemedicine to video, synchronous visits.[18] More than half of states did not have restrictions related to eligible provider types, with 10 others allowing for six or more provider types.[19] The vast inconsistency of these regulations also made it difficult for providers to offer cost-effective telemedicine services across locations.

Expansion during the Pandemic

COVID-19 was declared a public health emergency (PHE) on January 31, 2020, and a national emergency on March 13, 2020.[20] Subsequent to this declaration, and the shutdowns and gathering restrictions that followed, telemedicine and remote care became vital for many who could not visit their providers in person or were reticent to visit the hospital due to exposure concerns. After the start of the PHE, telemedicine quickly became routine for Medicare beneficiaries. From March to early July 2020, over 10 million beneficiaries received care through telemedicine, compared with only

9 Center for Medicare & Medicaid Services, "CY 2021 PFS Final Rule List of Medicare Telehealth Services (updated 12/21/2020) (ZIP)," available at https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f.

10 Bob Herman, "Virtual reality: More insurers are embracing telehealth," *Modern Healthcare* (February 20, 2016), https://www.modernhealthcare.com/article/20160220/MAGAZINE/302209980/virtual-reality-more-insurers-are-embracing-telehealth.

11 Ibid.

12 Ann Mond Johnson et al., *2019 State of the States: Coverage & Reimbursement*, American Telemedicine Association, July 18, 2019, 4.

13 Ibid., 17.

14 Ibid., 19.

15 Nicol Turner Lee, Jack Karsten, and Jordan Roberts, "Removing regulatory barriers to telehealth before and after COVID-19," Brookings Institute (May 6, 2020), 6, https://www.brookings.edu/research/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/.

16 Ibid.

17 Ann Mond Johnson et al., *2019 State of the States: Coverage & Reimbursement*, American Telemedicine Association, July 18, 2019, 4.

18 Ibid., 9.

19 Ibid., 14.

20 The White House, "Proclamation on Declaring a National Emergency Concerning the Novel Coronavirus Disease (COVID-19) Outbreak," March 13, 2020, https://trumpwhitehouse.archives.gov/presidential-actions/proclamation-declaring-national-emergency-concerning-novel-coronavirus-disease-covid-19-outbreak/.

14,000 per week at the start of 2020.[21] Specifically, telemedicine utilization rates for Medicare primary visits soared from 0.1 percent prior to February 2020 to 43.5 percent by April 2020.[22] All states, as well as both primary and specialty care physicians, have experienced increases in the number of telemedicine visits.[23]

Several reimbursement and regulation policy changes made this dramatic expansion possible. First, on March 17, 2020, CMS released waivers that:

- Reduced the barriers to providers by allowing beneficiaries to receive care wherever they were located, including in their homes, and by allowing physicians to treat patients outside of the state in which they are licensed;
- Exempted from Health Insurance Portability and Accountability Act (HIPAA) penalties providers who had acted in good faith, but had nonetheless committed a privacy violation by using unencrypted video programs, such as Skype or FaceTime, to conduct telemedicine visits;
- Expanded telemedicine reimbursement coverage to 135 new services, including emergency department visits; and
- Increased the types of providers that can conduct telemedicine visits to include "physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals."[24]

Because telemedicine is reimbursed on the basis of services conducted, CMS's expansion of covered services was vital for sustainable reimbursement.

Further legislation that played a role in expanding Medicare coverage included the Coronavirus Aid, Relief, and Economic Security (CARES) Act, which delegated $200 million to the Federal Communications Commission (FCC) to expand telemedicine services and infrastructure.[25] A March 30, 2020, release of regulatory changes from CMS established a pay parity rule for telemedicine visits, so that they would be reimbursed at the same rate as in-person visits, and extended coverage to more than 80 additional services, including emergency department visits, initial visits, discharges from nursing facilities, and home visits.[26] Because telemedicine is reimbursed on the basis of services conducted, CMS's expansion of covered

21 Centers for Medicare & Medicaid Services, "Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas," August 3, 2020, https://www.cms.gov/newsroom/press-releases/trump-administration-proposes-expand-telehealth-benefits-permanently-medicare-beneficiaries-beyond.

22 U.S. Department of Health & Human Services, "HHS Issues New Report Highlighting Dramatic Trends in Medicare Beneficiary Telehealth Utilization amid COVID-19," July 28, 2020, https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html.

23 Ibid.

24 Ibid.; Centers for Medicare & Medicaid Services, "Medicare Telemedicine Health Care Provider Fact Sheet," March 17, 2020, https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet.

25 Nicol Turner Lee, Jack Karsten, and Jordan Roberts, "Removing regulatory barriers to telehealth before and after COVID-19," Brookings Institute (May 6, 2020), 14, https://www.brookings.edu/research/removing-regulatory-barriers-to-telehealth-before-and-after-covid-19/.

26 Centers for Medicare & Medicaid Services, "Additional Background: Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge," March 30, 2020, https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient.

services was vital for sustainable reimbursement. In fact, in CMS's 2021 final payment rule for skilled nursing facilities (SNFs), more provisions were included to help providers care for patients through telemedicine, including adding new codes to allow Medicare beneficiaries greater access to virtual care services.[27] The newest code additions, which include physician telephone evaluation and management (E/M) services, represent an ongoing expansion of telehealth codes by CMS that will continue at least over the course of the pandemic and possibly beyond it.[28]

Most private insurers have also expanded their telemedicine benefits since the start of the pandemic, allowing for greater coverage and incentives for patients to utilize these services. Many waived out-of-pocket costs and co-payments for COVID-19 and telemedicine patients, but began rolling back these benefits over the summer after only a few months of coverage.[29] Many insurers have changed rates throughout the pandemic and are covering telemedicine services much less generously than Medicare, which will generally cover most of its expanded telemedicine services until at least the end of the PHE period.[30] In fact, several private payors halted their telemedicine copay waivers beginning in October 2020 for certain non-COVID-19-related services, a move that may raise costs for some patients.[31] This recent trend of decreasing utilization for virtual visits (although these rates are still many times higher than in 2019) may be a sign of providers' frustrations with these quickly-withdrawn reimbursement allowances and rate changes.[32] The sustainability of telemedicine has been questioned by many, and those who had not already integrated this technology before or at the start of the pandemic may be wary of expanding these services while reimbursement policies continue to be inconsistent and uncertain. Current reimbursement amounts for many services, such as telephone visits, are small and may not be sustainable for providers who have yet to establish telemedicine services.[33] The initial capital investment in telemedicine can be intimidating and may not make financial sense for many providers. Telemedicine software can cost between $20 and $500 per user per month,[34] while the hardware (and training) can cost thousands of dollars

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27 Centers for Medicare & Medicaid Services, "COVID-19: Coverage of Physician Telehealth Services Provided to SNF Residents," July 31, 2020, https://www.cms.gov/files/document/2020-07-31-mlnc-se.pdf.
28 Ibid.
29 Jayne O'Donnell and Ken Alltucker, "Telehealth can be lifesaving amid COVID-19, yet as virus rages, insurance companies look to scale back," *USA Today*, July 3, 2020, https://www.usatoday.com/story/news/2020/07/03/despite-covid-19-increase-insurance-companies-pull-back-telehealth/5352297002/.
30 Ibid.
31 Rebecca Robbins and Erin Brodwin, "As insurers move this week to stop waiving telehealth copays, patients may have to pay more for virtual care," *STAT News*, September 29, 2020, https://www.statnews.com/2020/09/29/united-healthcare-anthem-telemedicine-coverage-insurers/.
32 Jayne O'Donnell and Ken Alltucker, "Telehealth can be lifesaving amid COVID-19, yet as virus rages, insurance companies look to scale back," *USA Today*, July 3, 2020, https://www.usatoday.com/story/news/2020/07/03/despite-covid-19-increase-insurance-companies-pull-back-telehealth/5352297002/.
33 Ibid.
34 Adam Uzialko, "The State of Telemedicine," *Business.com*, November 11, 2019, https://www.business.com/articles/telemedicine-software-and-medical-practices/.

each, meaning a medical practice may conservatively spend more than $50,000 just to launch its telemedicine program.[35] Especially for smaller providers, such an initial investment may not be feasible.

Potential Future Reimbursement Trends

While the future of telemedicine reimbursement post-COVID-19 seems uncertain, CMS has recently released payment rules that seem to indicate that some telemedicine regulatory relaxations will remain in place, including the 2021 MPFS final rule and new payment models for rural providers and accountable care organizations (ACOs). In CMS's finalized rule, reimbursement coverage for several telemedicine services was permanently implemented or temporarily expanded. Seven telemedicine services, such as E/M services and some visits for patients with cognitive impairment, are proposed to be permanently covered,[36] while payments for 12 other telemedicine services, such as emergency department visits, are proposed to be extended only temporarily, until the end of the calendar year in which the COVID-19 PHE officially ends.[37] Seventy-four codes that have been reimbursed during the COVID-19 PHE will be removed immediately after the end of this PHE.[38]

In CMS's finalized rule, reimbursement coverage for several telemedicine services was permanently implemented or temporarily expanded.

In a July 26, 2021, letter to Congress, however, more than 400 organizations and companies—including the American Medical Association, the American Telehealth Association, the Alliance for Connected Care, Google, and Amazon—urged congressional leaders to enact permanent telemedicine reform beyond the end of the pandemic.[39] Perhaps in acknowledgment of such sentiment, CMS suggested allowing certain telemedicine services to be covered by Medicare until December 31, 2023, under the 2022 MPFS proposed rule.[40] CMS's goal in extending coverage for telemedicine services is to alleviate concerns for patients and providers by creating a "glide path" while CMS gathers information on the long-term effects of expanding services.[41] Although CMS has proposed allowing coverage for telemedicine services through 2023, congressional action may still be required to enable CMS to transition these services beyond the end of the pandemic and ensure telemedicine is regulated

35 Ibid.
36 Centers for Medicare & Medicaid Services, "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2021," December 1, 2020, https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1.
37 Ibid.
38 Rachel B. Goodman and Nathaniel M. Lacktman, "COVID-19: Here's What CMS Will Do With the Temporary Telemedicine Codes When the PHE Ends," Foley & Lardner LLP, August 12, 2020, https://www.foley.com/en/insights/publications/2020/08/covid-19-cms-temporary-telehealth-codes-phe-ends.
39 American Academy of Family Physicians, "RE: Priorities for Medicare Telehealth Reform," Letter to Congressional Leaders, July 26, 2021, https://www.aafp.org/dam/AAFP/documents/advocacy/health_it/telehealth/LT-CongressLeadership-PostCOVIDTelehealthPriorities-072621.pdf.
40 Centers for Medicare & Medicaid Services, "CMS Proposes Physician Payment Rule to Improve Health Equity, Patient Access," July 13, 2021, https://www.cms.gov/newsroom/press-releases/cms-proposes-physician-payment-rule-improve-health-equity-patient-access.
41 Ibid.

under the same standards as in-person services.[42]

Further, to support rural providers, CMS has proposed a new Community Health Access and Rural Transformation (CHART) model. This model was created in response to an August 3, 2020, executive order, which highlighted opportunities for investment in technological infrastructure for rural areas and urged the U.S. Department of Health & Human Services (HHS) to develop a new payment model with increased flexibility, more predictable payments, and quality incentives for rural hospitals.[43] Rural patients struggle with access to healthcare, and telemedicine provides a unique challenge for rural patients because of a lack of infrastructure. Lower adoption and utilization rates in rural communities exemplify this idea, as do reports that, for example, indicate internet issues for about one in five adults living in rural areas.[44] The CHART model will operate through two value-based reimbursement "tracks": (1) the Community Transformation Track and (2) the ACO Transformation Track.[45] Among other benefits, these tracks will continue telemedicine expansion post-COVID-19 for rural providers.[46]

Conclusion

Telemedicine's rapid expansion during COVID-19 now faces an uncertain future. A lack of reimbursement, as well as widely varied reimbursement policies among states and payors, has long been a major barrier to entry for many providers pre-COVID-19. Telemedicine utilization, however, has been increasing steadily over the past several years with a large, unprecedented rise in March and April 2020, at the start of the COVID-19 PHE. Utilization and adoption rates remain higher than ever before, but many providers seem hesitant to invest in telemedicine long-term as public and private payors begin to plan pullbacks in benefits and service coverage. Still, CMS is planning to make some of the 135 services under its expanded coverage in March 2020 permanent or available on a longer-term basis until the end of the PHE. If these telemedicine services indeed continue to be reimbursed, and policy changes continue to be implemented, the future of telemedicine may be bright for patients and providers alike. Reimbursement will either provide an incentive or barrier to this future and will require cooperation and consistency across states and payors.

Part III of this series will examine the regulatory environment for telemedicine, with a specific focus on fraud and abuse laws. VE

Todd A. Zigrang, MBA, MHA, FACHE, CVA, ASA, is president of Health Capital Consultants, where he focuses on the areas of valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience and has participated in the development of a physician owned, multispecialty management service organization and networks involving a wide range of specialties, physician owned hospitals, as well as several limited liability companies for acquiring acute care and specialty hospitals, ASCs, and other ancillary facilities. Email: tzigrang@healthcapital.com.

Jessica L. Bailey-Wheaton, Esq., serves as vice president and general counsel of Health Capital Consultants, where she conducts project management and consulting services related to the impact of both federal and state regulations on healthcare exempt organization transactions, and provides research services necessary to support certified opinions of value related to the fair market value and commercial reasonableness of transactions related to healthcare enterprises, assets, and services. Email: jbailey@ healthcapital.com.

42 American Health Law Association, "430 Organizations Call for Permanent Telehealth Reform," *Health Law Weekly,* July 30, 2021, https://www.americanhealthlaw.org/content-library/health-law-weekly/article/80da0e82-a174-402b-bcfe-a504b156118b/430-Organizations-Sign-on-to-Latest-Push-to-Make-T?utm_campaign=Weekly+eNewsletters&Token=d1c7a803-ea84-44ad-95bf-5bec4c99462b (subscription required).

43 "Improving Rural Health and Telehealth Access," Exec. Order No. 13941, 85 Fed. Reg. 47,881 (August 3, 2020), https://www.federalregister.gov/documents/2020/08/06/2020-17364/improving-rural-health-and-telehealth-access.

44 U.S. Department of Health & Human Services, "HHS Issues New Report Highlighting Dramatic Trends in Medicare Beneficiary Telehealth Utilization amid COVID-19," July 28, 2020, https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html; National Public Radio, *Life in Rural America: Part II*," May 2019, 10, https://media.npr.org/documents/2019/may/NPR-RWJF-HARVARD_Rural_Poll_Part_2.pdf.

45 Centers for Medicare & Medicaid Services, "Community Health Access and Rural Transformation (CHART) Model Fact Sheet," August 11, 2020, https://www.cms.gov/newsroom/fact-sheets/community-health-access-and-rural-transformation-chart-model-fact-sheet.

46 Ibid.