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Valuation of Telemedicine: Reimbursement

Introduction

The second installment in this five-part *Health Capital Topics* series on the valuation of telemedicine will focus 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. The first installment in this series introduced telemedicine and its increasing importance to, and popularity among, providers and patients. It also discussed the current and future challenges related to telemedicine, many of which hinge upon reimbursement restrictions and regulations.[2]

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).[3] 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.[4] A patient's location when receiving care, called the *originating site*, was, until the CONNECT Act, an important factor in determining reimbursement eligibility.[5] In 2019, whether an originating site (to which Medicare pays a facility fee – $26.65 in 2019[6]) was authorized depended on the facility's geographic area.[7] States also had differing rules on the patient setting, with 29 states not including patient setting as a condition for payment, and 12 states recognizing school, and 12 states recognizing the home, as originating sites.[8] Medicare also restricted which practitioners could receive payments for covered telemedicine services.[9] Covered services have also traditionally been limited, although CMS has added new services to this list every year through the *Medicare Physician Fee Schedule* (MPFS). At the beginning of 2020, 101 telemedicine services were reimbursed by Medicare.[10]

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 a growing interest from providers and patients 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, such as for behavioral health, dermatology, radiology, infectious diseases, and stroke.[11] Around that same time, however, only 15% 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 practice.[12]

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 ten states had not yet enacted substantive policies for telemedicine reimbursement.[13] Additionally, 21 and 28 states have coverage and payment parity policies related to Medicaid, respectively.[14] States more often regulate private payors, with 36 states having coverage parity and 16 states having payment parity related to private payments.[15] These parity policies may provide strong incentives for the adoption and viability of telemedicine technology for physician practices.[16] However, at the same time, equal payments undermine the cost-saving argument of telemedicine and create complications for technology adoption.[17]

In the 2019 report, the ATA further stated that 29 states do not include patient setting as a condition for payment.[18] Further, the majority of states also recognize

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modalities of telemedicine delivery other than synchronous technology, with some states even allowing for audio-only visits; however, 16 states still limit telemedicine to just video, synchronous visits.[19] More than half of states did not have restrictions related to eligible provider types, with ten others allowing for six or more provider types.[20] The vast inconsistency of these regulations also created difficulties for providers to provide 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.[21] 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 provider 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 14,000 per week at the start of 2020.[22] Specifically, telemedicine utilization rates for Medicare primary visits soared from 0.1% prior to February 2020 to 43.5% by April.[23] All states, as well as both primary and specialty care physicians, have experienced increases in the number of telemedicine visits.[24]

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

(1) Reduced the barriers to providers by allowing beneficiaries to receive care wherever they were located, including in their home, and by allowing physicians to treat patients outside of the state wherein they are licensed;

(2) Exempted 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 free from *Health Insurance Portability and Accountability Act* (HIPAA) penalties;

(3) Expanded telemedicine reimbursement coverage to 135 new services, including emergency department visits; and,

(4) Increased the types of providers that can conduct telemedicine visits to: "*physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals*."[25]

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.[26] 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 further to more than 80 added services, which included emergency department visits, initial visits, discharges from nursing facilities, and home visits.[27] Because telemedicine is reimbursed on the basis of services conducted, CMS's expansion of covered 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.[28] 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.[29]

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 and telemedicine patients, but began rolling back these benefits over the summer after only a few months of coverage.[30] 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.[31] In fact, several private payors halted their telemedicine copay waivers beginning in October 2020 for certain non-COVID-19-related services, a move which may raise costs for some patients.[32] 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.[33] 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 weary 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.[34] 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,[35] while the hardware (and training) can cost thousands of dollars each, meaning a medical practice may conservatively spend more than $50,000 just to launch their telemedicine program.[36] Especially for smaller providers, such an initial investment may not be feasible.

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Potential Future Reimbursement Trends

While the future of telemedicine reimbursement post-COVID-19 seems uncertain, CMS has recently released payment legislation that seems to indicate that some telemedicine regulatory relaxations will remain in place, including the 2021 MPFS proposed rule and new payment models for rural providers and *accountable care organizations* (ACOs). In CMS's proposed rule, reimbursement coverage for several telemedicine services was permanently implemented or temporarily expanded. Nine telemedicine services such as E/M services and some visits for patients with cognitive impairment are proposed to be permanently covered,[37] while payments for 13 other telemedicine services, such as emergency department visits, are proposed to be extended only temporarily, until the end of the *calendar year* (CY) in which the COVID-19 PHE officially ends.[38] Seventy-four codes that have been reimbursed during the COVID-19 PHE will be removed immediately after the end of this PHE.[39]

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 and Human Services* (HHS) to develop a new payment model with increased flexibility, more predictable payments, and quality incentives for rural hospitals.[40] 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 other reports which, for example, indicate internet issues for about one in five adults living in rural areas.[41] The CHART model will operate through two value-based reimbursement "*tracks*": (1) the *Community Transformation Track* and (2) the *ACO Transformation Track*.[42] Among other benefits, both of these tracks will continue telemedicine expansion post-COVID-19 for rural providers.[43]

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 to pull back 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.

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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.

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