Telemedicine's Post-Pandemic Outlook

How will patient acceptance of telemedicine/telehealth balance against logistical and regulatory hurdles?

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Telemedicine has rapidly advanced over the past couple of decades. 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. The utilization of this technology significantly accelerated during the COVID-19 pandemic—made possible by a number of regulatory relaxations and changes. The popularity of this service line over the past year has spurred conversation regarding the place of telemedicine/telehealth in the health care industry at the conclusion of the COVID-19 public health emergency (PHE). To clarify terminology, "telemedicine" refers specifically to remote clinical services, while "telehealth" refers to a broader range of remote clinical and non-clinical services.

Review of Telemedicine Expansions & Relaxations

In response to the COVID-19 pandemic, federal and state governments enacted an array of regulatory waivers, relaxations and expansions related to telemedicine. This was done in an effort to help medical practices whose revenue was decimated as a result of canceled in-person office visits, as well as provide backup to hospital providers who were overwhelmed by the virus. It also gave patients an alternative to in-person medical treatment without the risk of infecting themselves or others. Some of those regulatory actions include:

1. The $8.3 billion Coronavirus Preparedness and Response Supplemental Appropriations Act that was enacted in March 2020 gave authority to the Secretary of Health and Human Services (HHS) to lift some telehealth delivery restrictions, such as the "originating site" requirements for telehealth services.[1]
2. The $2 trillion Coronavirus Aid, Relief and Economic Security (CARES) Act—passed in March 2020—included a number of additional provisions related to telehealth services such as:
   - Allocating $200 million to the Federal Communications Commission (FCC) for telehealth development support;
   - Waiving the requirement that a physician must have treated a patient within the last three years to receive payment for telehealth;
   - Allowing hospice care to be recertified via telehealth; and,
   - Expanding eligibility for home dialysis patients to receive telehealth.[2]
3. Centers of Medicare & Medicaid Services (CMS) Guidance—CMS issued new rules and waived other rules, effective through the end of the PHE, which:
   - Allow beneficiaries to receive care wherever they were located, including in their home;
   - Allow physicians to treat patients (both new and established) outside of the state in which they are licensed;
   - Expand the types of providers that can conduct telemedicine visits to include physical therapists, occupational therapists and speech language pathologists;
   - Expand telemedicine reimbursement coverage to 135 new services, including emergency department visits;
   - Establish a pay parity rule for telemedicine visits, so they are reimbursed at the same rate as in-person visits; and,
   - Extend coverage to over 80 additional services, including emergency department visits, initial visits, discharges from nursing facilities and home visits.[3,4]
4. Drug Enforcement Agency (DEA) guidance – Allows physicians to prescribe controlled substances via telemedicine, without an in-person examination.[5]


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5. State waivers – 41 states enacted waivers for out-of-state physicians, preexisting relationships and audio-only requirements.[6]
6. August 3, 2020 executive order – Allows some of the 135 telehealth services that were originally waived on a temporary basis to be permanently delivered via telemedicine technology going forward.[7]
7. The 2021 Medicare Physician Fee Schedule (MPFS) final rule – Added numerous telemedicine procedure codes, either permanently or temporarily, to those currently covered by Medicare.[8]

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Post-Pandemic Interest in Telemedicine

Over the past year, a multitude of studies has been conducted related to the utilization, efficiency and quality of telemedicine. Analyses suggest that telehealth could be further expanded in the coming years, with anywhere from $106 billion up to $250 billion of current U.S. health care spending that could be "virtualized" (up from $29 billion in 2020).[9,10] This is in part due to the popularity that telemedicine has achieved among patients, providers and payers, although to differing degrees. The interest of each of these stakeholders in continuing the level of telemedicine services currently in place—as well as the federal government's appetite for extending or even expanding the coverage of and payment for telemedicine—will significantly drive the future outlook for these services.

Patient Interest. While patients were relatively apathetic toward telemedicine prior to the COVID-19, exposure to the technology has largely changed their minds. Approximately 61% of patients have accessed telehealth services as of March 2021 (compared to only 11% in 2019);[11] importantly, 74% of those who utilized telehealth reported high satisfaction.[12] Going forward, nearly 88% of survey respondents want to continue using telehealth for non-urgent consultations post-pandemic.[9,13]

Despite these assertions, the number of telemedicine visits dropped precipitously in the latter part of 2020 as patients felt comfortable enough to return to in-office visits.[14] In particular, telemedicine usage among privately insured individuals fell approximately 18.6% and 15% in January and February 2021, respectively.[15] Further, future reforms will still likely rescind the current waiver allowing telemedicine visits via FaceTime, Zoom and other non-HIPAA-compliant platforms, which may make virtual care less convenient for patients, further deteriorating their asserted interest.[14]

Provider Interest. Similar to patients, providers' interest in telemedicine has also increased, with a study reporting that 54% of providers view telemedicine more favorably, and 64% are more comfortable using it than before COVID-19.[12] However, the extra work required of non-physician providers to serve patients via telehealth, and the impending requirement that telehealth services be performed on a HIPAA-compliant platform, may erode that desire to continue providing telehealth services. A recent analysis of nursing activities performed for type 2 diabetes and hypertension patients found that nurses performed approximately twice as many activities with telehealth patients compared to in-person patients.[16] This additional work could result in additional nurse burnout, accelerating staffing shortages.[17] Further, as any future reforms will still require the use of HIPAA-compliant platforms,[14] requiring providers to come up with the capital necessary to purchase a telemedicine-specific platform may serve as an unscalable barrier, especially for smaller practices.

These required resources to operate telemedicine services going forward may be moderated by recent research indicating that practices utilizing telemedicine may secure more downstream (i.e., follow-up) care. An analysis of privately insured patients between 2016 and 2019 found that those who used telemedicine for upper respiratory infections were more likely to attend an in-person visit within seven days (10%) than those who sought in-person care (5.9%).[18] Researchers did not quantify the value of the follow-up care, but they did note that the telemedicine cohort had fewer emergency department visits (0.5% versus 0.6%) and more subsequent office, urgent care and telemedicine visits.

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Payer Interest. ***Private Payers.*** Prior to the COVID-19 pandemic, most private payers offered some level of telemedicine coverage. Due to the federal government's outsized presence in the health care marketplace, most private payers tend to follow Medicare's lead on reimbursement. So when Medicare expanded telemedicine beginning in March 2020, most private payers did the same. However, private payers have largely already ended their temporary telemedicine expansion policies.[19]

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Additionally, while private insurers remain interested in telemedicine, their alignment focus has largely been with telemedicine companies and not providers. Therefore, private reimbursement for telemedicine services may not be a windfall for practices, as payers may direct patients to their own platform that utilizes health plan-employed providers.[14]

Public Payers. CMS in particular has indicated its interest in maintaining some of the telemedicine expansions and relaxations it put in place during the PHE. For example, the 2021 MPFS permanently added over 60 services to the Medicare telemedicine list.[8] Additionally, CMS announced in December 2020 that it was commissioning a study of the telehealth flexibilities it has provided during the COVID-19 pandemic, which "will explore new opportunities for services where telehealth and virtual care supervision and remote monitoring can be used to more efficiently bring care to patients and to enhance program integrity,"[8] indicating the agency's belief that telehealth will endure past the end of the pandemic.[20]

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However, as CMS has pointed out, "Medicare does not have the statutory authority to pay for telehealth to beneficiaries outside of rural areas or, with certain exceptions, allow beneficiaries to receive telehealth in their home."[8] Therefore, congressional intervention may be required for more fundamental changes to telehealth coverage.

Congressional Interest. Congress has also indicated some willingness to expand telehealth coverage over the past year in a slew of proposed (largely bipartisan) legislation. To date, the Alliance for Connected Care has identified 19 telehealth-related bills,[21] the most notable of which are summarized below:

(1) *Telehealth Modernization Act* (Senate Bill) – Would allow rural health clinics and federally qualified health centers to serve as the distant site; a beneficiary's home to serve as the originating site for all services (other than for only certain services); and all types of practitioners to furnish telehealth services.[22]

(2) *Protecting Access to Post-COVID-19 Telehealth Act* (House Bill) – Would eliminate most geographic and originating site restrictions on Medicare coverage and include the patient's home as an eligible distant site;[23,24] and,

(3) *The Expanded Telehealth Access Act* (House Bill) – Would permanently expand Medicare-covered telehealth services for physical therapists, occupational therapists, audiologists and speech and language pathologists.[25]

Despite this activity, lawmakers have expressed concerns related to telehealth expansion, including whether it may lead to overutilization of health care services, result in health care fraud and abuse, or intensify current disparities in health care.[26] Some industry commentators believe that specific areas of telehealth, where physical examinations are not needed (such as behavioral health and chronic care management), may be an easier sell.[14]

Conclusion

Telemedicine/telehealth technology has undoubtedly been one of the few beneficiaries of the COVID-19 pandemic. The significant number of actions taken over the past year to relax regulatory and reimbursement restrictions has resulted in a windfall of demand for telehealth providers, and may be unfeasible to reverse at the conclusion of the pandemic, as patients and providers become more comfortable with the new technology. As has been seen time and again in health care, once industry stakeholders get used to a new benefit or technology, it is extremely difficult to take it away.

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records which in turn may reduce medical errors; 2) improved adherence to medications when a patient can review their chart and the medication instructions; 3) a stronger relationship between patients and their physicians when a patient is more involved in their health care and feels more in control; and 4) improvement in monitoring and treating chronic illness, among other things.[11]

While the Final Rule may cause additional challenges at the outset in terms of provider compliance, increased patient questions, and the time associated with providers trying to modify their documentation style when they know their notes may be read by a patient, many are still anticipating an overall improvement in the patient experience and the health care system.

Conclusion

Admittedly, the Final Rule has a lot of moving parts and still more convoluted language. The implementation and deadlines for compliance with the Final Rule have been ever-changing during the pandemic and enforcement has the potential to be further delayed. While the transition to enhance patient care and transparency may not be easy, it should be worth it.

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