

CENTERING ON CORONAVIRUS

# THE EXPANSION OF TELEHEALTH

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# Centering on Coronavirus: The Expansion of Telehealth

Traditionally a supplementary and underutilized form of health care delivery, telehealth is now one of the frontline pillars of defense against the COVID-19 pandemic. In April 2020, a Morning Consult poll found that 23% of adults have used telemedicine services since the outbreak of COVID-19, and virtual visits surged 50% in March 2020, compared to February.

Telehealth adoption has been accelerated by recent regulatory changes to reimbursement policies, data privacy requirements, and cross-state licensing regimes. The Centers for Medicare & Medicaid Services (CMS), the Department of Health & Human Services (HHS), state Medicaid programs, and private insurance companies all made changes that had been discussed—and continually delayed—for years.

By keeping patients away from busy hospitals, telehealth is helping to reduce the burden on overwhelmed care centers and the risk of infections. However, the potential applications of telehealth extend far beyond this crisis. It could help ease longstanding problems with health care costs and accessibility, particularly in underserved communities. In this issue brief, The New Center looks deeper at the changes to telehealth policy and provides recommendations expanding this vital tool long into the future, including:

- Modernizing Medicare & state Medicaid to reimburse for a more comprehensive array of telehealth services.
- Compelling states to reexamine the “private payer” laws, which mandate telehealth coverage parameters for private insurance companies.
- Promoting interstate provider licensing compacts.
- Investing in more research for under-examined aspects of telehealth delivery.

## What are Telemedicine and Telehealth?

While “telehealth” and “telemedicine” are often used interchangeably, telehealth more broadly encompasses clinical and non-clinical services, while telemedicine uses specific technology to provide remote clinical services to patients. The Agency for Healthcare Research and Quality describes telehealth as “the use of telecommunications technologies to deliver health-related services and information that support patient care, administrative activities, and health education.” Telehealth is traditionally broken down into three “modalities,” or technological means of gathering, saving, and sharing patient information: live video, store-and-forward, and remote patient monitoring (RPM).

The most widely reimbursed modality is live video—which requires the patient to have internet and audiovisual technologies such as a computer or smartphone. Store-and-forward telemedicine, which is less common, is when a doctor collects patient information (e.g., lab results or imaging studies) and forwards that information to another provider. Remote patient monitoring tracks patient health information (e.g., self-reports of symptoms or vitals monitoring) and relays that information to a doctor. RPM is increasingly used in clinical trials to enhance study design, streamline the participant enrollment process, and promote patient engagement—yielding more efficient, cost-effective, and comprehensive research.



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## Changes in Telehealth Regulation, 2019 and 2020 in Review

### CHANGES TO MEDICARE

In 2001, Congress amended the Social Security Act to provide telehealth coverage to Medicare beneficiaries, primarily as supplemental care to rural patients. Coverage of telehealth services was limited to (a) live “two-way” video conferencing, whereby the patient and doctor communicate using real-time audiovisual technology (as opposed to a nonvisual telephone call or text messaging); and (b) specific “originating sites,” the area where patients receive telehealth services, which were required to be located in rural areas.

Increasingly since 2001, Medicare has been reimbursing for a broader range of non-face-to-face health services, such as audio-only telephone check-ins, store-and-forward, and interprofessional (i.e., doctor-to-doctor) internet consultation. Despite notable service expansions by 2019, Medicare still had several barriers that prevented patients from accessing telehealth services. To qualify for Medicare reimbursement:

- Many services were required to be delivered through live video, as opposed to audio-only or other forms of communication.
- The patient had to be located in a “rural area,” narrowly-defined as a Health Professional Shortage Area (HPSA) or outside a Metropolitan Statistical Area (MSA).
- Patients could not conduct telehealth visits from home, but instead had to travel to an “eligible facility” to receive telehealth services. Eligible facilities for telehealth are typically restricted to hospitals, provider offices, rural health clinics, and other professional health settings.

On March 17, 2020, the CMS announced extended Medicare telehealth coverage following the Trump administration’s COVID-19 national emergency declaration. In an unprecedented move, Medicare expanded services to allow for widespread telehealth adoption:

- Medicare expanded their coverage of more than 80 telehealth services—such as emergency department visits, initial nursing facility and discharge visits, and home visits—and provided “payment parity” for all of them, meaning that telehealth is reimbursed at the same rate as an in-person visit.
- Patients were permitted to receive telehealth appointments no matter where they lived, whereas they previously needed to live in a rural area.
- Patients were permitted to receive telehealth appointments in areas outside eligible facilities, such as their own homes.
- Patients were permitted to use video conferencing via smartphone, along with audio-only calls for some services.
- Patients were permitted to visit any doctor, including those with whom they had no prior relationship.
- All federal qualified health centers and rural health clinics became eligible to provide telehealth.

With new changes to Medicare, some have raised alarms about the possibility of fraud and inconsistent billing returns from telehealth services. During the COVID-19 emergency, telemedicine providers are permitted to waive patient deductibles and copayments to encourage virtual appointments.

CMS has traditionally labeled these waivers as illegal “kickbacks,” because if a patient has no financial responsibility for health services, they are less likely to complain about incorrect charges—complaints that help CMS more easily identify billing fraud. This risk seems particularly salient now, as one of the largest scams in U.S. history was uncovered last September when a fraudulent telehealth genetic testing scheme defrauded Medicare for more than \$2.1 billion.

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## CHANGES TO MEDICAID

Medicaid is jointly administered by the federal government and individual state governments. The federal government sets a broad range of guidelines for Medicaid programs, while the states have significant flexibility in setting insurance eligibility requirements and coverage parameters.

Last year marked a growing trend of expanded telehealth coverage in Medicaid programs. In 2019, all 50 states and Washington D.C. provided reimbursement for some form of live video conferencing between patients and doctors in their Medicaid programs. However, reimbursement for other forms of telemedicine is still lacking—only 16 state Medicaid programs reimburse for store-and-forward, while 23 state Medicaid programs reimburse for remote patient monitoring.

Forty-six states and D.C. have released updated health policies in the wake of the coronavirus pandemic to promote telehealth services. Thirty-eight states and D.C. have announced “payment parity” for telehealth, meaning that Medicaid will cover telehealth services at the same rate as face-to-face visits. The majority of states began allowing Medicaid beneficiaries to access services outside of eligible facilities and through audio-only technologies.

This means that telephone calls from a patient’s home—one of the most accessible and convenient means of communicating—will be covered. Additionally, states are expanding the types of professional providers covered to provide telehealth under Medicaid, including federal qualified health centers and rural health clinics.

## CHANGES FOR COMMERCIAL INSURERS

In 2019, several states made changes requiring private commercial insurers to expand their reimbursement of telehealth services. Each state expanded telehealth provisions in a different way, with the most substantial changes being made to the following categories:

- Payment parity—California (Assembly Bill 744), Georgia (Senate Bill 118), and New Mexico (Senate Bill 354).
- Requiring private payers to reimburse telehealth services, but not necessarily requiring payment parity—South Dakota (Senate Bill 137) and Ohio (House Bill 166).
- Expanding telemedicine coverage to include store-and-forward—New Mexico (Senate Bill 354) and Arizona (Senate Bill 1089).
- Expanding telemedicine coverage to include remote patient monitoring—New Mexico (Senate Bill 354), Virginia (Senate Bill 1221), and Arizona (Senate Bill 1089).
- Barring insurance companies from denying coverage of telehealth services by delivery platform (e.g., video conferencing apps and telephone calls)—California (Assembly Bill 744) and Texas (House Bill 3345).

When not mandated by the state, private insurance companies are free to decide which telehealth services their plans will cover. Therefore, changes to telehealth benefits as a result of COVID-19 vary by insurer. All of America’s top ten health insurance companies have expanded telehealth coverage during the pandemic—first and foremost, for COVID-19 testing and screening.

For example, Cigna is waiving out-of-pocket costs for testing-related telehealth visits. Some insurers, like Humana, are going even further to cover all telehealth services for members using in-network providers, even for non-COVID-19-related illnesses. Similarly, Blue Cross Blue Shield of Massachusetts lowered several long-held barriers to telehealth, such as mandates on member locations, delivery technologies, and reimbursement rates—allowing patients to be seen anywhere, by phone or video, with payment parity.

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## CHANGES TO HIPAA

Patients' health data is protected under the Health Insurance Portability and Accountability Act (HIPAA), which requires health care providers to protect patient privacy and provide individuals control over how their health data is used. Historically, HIPAA has barred providers from using popular video conferencing apps if they did not meet specific cybersecurity benchmarks that ensure patients' confidentiality.

On March 17, 2020, the U.S. Department of Health and Human Services Office of Civil Rights announced that it will “exercise enforcement discretion and will waive potential penalties for HIPAA violations against health care providers that serve patients in good faith through everyday communications technologies during the COVID-19 nationwide public health emergency.” HHS has stated that telehealth providers during this time will not be in violation of HIPAA for using apps such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom, or Skype. This move has prompted a host of concerns over health data privacy and security, with critics worried that third-party technology companies could be targeted by profiteering schemes.

## CHANGES TO LICENSING REQUIREMENTS

Most policies regarding medical licenses are defined by individual states, typically requiring doctors to be licensed in the state where they practice. As of late 2019, 12 states require a specially issued license for providers to practice telemedicine, on top of a general medical license. In recent years, some states have pushed to allow doctors from bordering states to practice temporarily without additional licenses. However, these doctors are barred from opening an office outside their licensure. Many providers are deterred from applying for licenses in multiple states, as the process can be tedious and costly.

In 2019, the number of states participating in interstate licensing agreements continued to grow. There are four primary interstate licensure compacts that allow out-of-state licensed providers to practice in other participating states:

- The Interstate Medical Licensure Compact, which allows doctors to practice medicine in multiple states by completing just one application, and approves separate licenses from each state in which they intend to practice. This Compact has been approved in 29 states, D.C., and Guam, though some areas have yet to fully implement the program and issue licenses.
- The Nurses Licensure Compact, which allows nurses with interstate licenses to practice in any of the 32 member states, with two additional states set to implement the program in the near future.
- The Physical Therapy Compact, which allows physical therapy providers to practice in any of the 28 member states.
- The Psychology Interjurisdictional Compact, which allows psychologists to apply for certificates, either for telepsychology or in-person care, for its 12 member states.

Since the COVID-19 national emergency declaration, all 50 states and Washington, D.C. have begun to relax their telehealth licensing requirements. On March 15, 2020, the Department of Health & Human Services issued “Section 1135 waivers”, which implements sweeping reforms to the 2001 Social Security Act-based licensing laws. These waivers nullify requirements that health care professionals hold licenses in the state in which they provide services, now allowing doctors to practice anywhere in the United States if CMS approves their waiver. These regulations only apply to Medicare, Medicaid, and CHIP reimbursement. If a doctor wishes to see a privately-insured patient, state laws will govern whether he or she is permitted to practice without a state-specific license—a step that many states have already taken.

For example, in Alabama, the state established temporary emergency licensure processes to authorize physicians to provide health care to Alabamians diagnosed with COVID-19. Doctors who are licensed to practice in any U.S. state or Washington, D.C. are eligible for an emergency license in Alabama. Additionally, any Alabama doctor whose medical license recently expired will be able to reinstate it within 48 hours of applying, so long as their previous license was not subjected to discipline.

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## ADDITIONAL CARES ACT FUNDING

The \$2.2 trillion Coronavirus Aid, Relief, and Economic Security Act (CARES Act), passed on March 27, 2020, included \$200 million for the Federal Communications Commission (FCC) to widen telehealth services across the country. The funding is dedicated to rolling out the “COVID-19 Telehealth Program”, which focuses on providing telecommunications equipment, broadband connectivity, and medical devices to promote remote patient monitoring and virtual appointments. The FCC’s Universal Service Fund, which was established in 1997 to provide high-speed broadband access to underserved areas, will also begin to fund internet access for health care providers through the Connected Care Pilot program. (To learn more about COVID-19 and the digital divide, see our issue brief.)

## New Center Solutions: Opportunities for Telehealth Expansion

In a recent statement, CMS Administrator Seema Verma affirmed that “the genie's out of the bottle” in regard to the future of telehealth. Although most COVID-19-related telehealth regulations are expected to expire when the public health emergency declaration ends, policymakers are already thinking about maintaining and adopting permanent measures to further accelerate telehealth. Here are a few solutions that could make a significant difference.

### MODERNIZE MEDICARE & STATE MEDICAID PROGRAMS

CMS should continue telehealth coverage with payment parity. CMS has begun to cover 85 telehealth services—a critical measure that could service Americans long after the emergency declaration has ended. CMS should keep covering these services and look to expand to coverage of other telehealth services in the future, while ensuring equal payment for virtual services and in-person visits.

Patients should be at liberty to receive telehealth services in their own homes, which for many people is the most convenient and immediate form of care. Congress should permanently repeal the “originating site” requirement for Medicare reimbursement included in the Social Security Act of 2001. Additionally, only 19 state Medicaid programs explicitly recognize a patient’s home as a covered originating site, though it still may only be covered under exceptional circumstances. Like with Medicare, state legislatures should remove their originating site requirements.

It should be easier for patients to access telehealth over the phone and other technologies. In line with the expansions made by CMS during the pandemic, Medicare should cover both “audio and video capabilities that are used for two-way, real-time interactive communication.” Relaxed technological restrictions are particularly helpful for Medicare beneficiaries—half of U.S. households headed by a person age 65+ do not own a smartphone, and more than one-third don’t have an internet subscription. However, 91% of people 65+ own a cell phone—meaning that audio-only telehealth can reach significantly more older adults.

Studies have demonstrated that remote patient monitoring for high-cost Medicare beneficiaries with chronic diseases (e.g., those with congestive heart failure, diabetes, and COPD) can yield improved patient outcomes and cost reductions up to 13.3%, while store-and-forward can reduce unnecessary referrals and patient copays.

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In 2019, CMS added Medicare billing codes to the Physician Fee Schedule and Quality Payment Program for store-and-forward and remote patient monitoring services, with some notable limitations. However, though Medicare has taken this step forward, many states are lagging behind. Only 23 states cover remote patient monitoring, and only 16 states cover store-and-forward. CMS and state Medicaid programs should consult and conduct studies as to which services can reduce costs and improve patient outcomes using remote patient monitoring and store-and-forward.

## REEXAMINING PRIVATE PAYER LAWS

Federal law does not mandate private insurers to reimburse telehealth services in their plans—individual states have primarily regulated this issue. Currently, 40 states and D.C. have legislation requiring private insurance to at least partially reimburse telehealth services, though the scope of each state’s laws is highly varied. For example, only a handful of states mandate private insurers to provide payment parity for telehealth. In 2014, the Center for Connected Health Policy outlined key metrics for determining the comprehensiveness of private payer laws, including mandates for (a) payment parity, (b) reimbursement for multiple modalities, (c) originating site flexibility, and (d) provider and specialist flexibility. States should investigate the scope of their laws to determine if certain statutes inadvertently undermine telehealth rollout.

## MORE STATES SHOULD JOIN INTERSTATE COMPACTS

One of the fastest ways to relax licensing laws is for more states to join preexisting cross-state structures, as opposed to creating an entirely new national licensing scheme administered by the federal government, which would prompt additional logistical and regulatory struggles. This move could be particularly appealing for the many states weighing entering interstate compacts in their state legislatures, such as New York, Pennsylvania, Missouri, and Louisiana. For states that have not released any licensing legislation, the Federation of State Medical Boards (FSMB) has drafted model policy for entering the Interstate Medical Licensure Compact, which has served as a template for nearly half of the member states.

## FURTHER RESEARCH FOR UNDER-EXAMINED ASPECTS OF TELEHEALTH DELIVERY

While the potential for telehealth has been consistently demonstrated through studies of home monitoring and communication and counseling for patients with chronic conditions, the body of telehealth research is still relatively small. As it stands, the public health potential for telehealth is unclear when used in unique circumstances (e.g., a global pandemic), locations (e.g., intensive care units), and applications (e.g., pediatric health). The federal government and states should support future research with pre-defined measures of effectiveness based on patient outcomes and cost savings. Some areas for telehealth research, as determined by the Agency for Healthcare Research and Quality, include:

- Defining the types of consultations and conditions that best lend themselves to telehealth, particularly given the rapid pace of technological innovation that expands telehealth capabilities.
- Clinical applications being rolled out in response to the pandemic (e.g., primary care, pre-operative assessment, and post-operative care.)
- Studies focused on the implementation of new telehealth programs, focusing on adaptability to rapid changes (needed to combat a pandemic) in funding readiness, necessary technical assistance, and reimbursement structures.



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## ABOUT CENTERING ON CORONAVIRUS

Centering on Coronavirus is a new policy series from The New Center that provides insights and analyses of how coronavirus is progressing, how it is impacting our health system, economy and workers, and the extraordinary human, policy, and technological resources that are being mobilized to fight it.

## ABOUT THE NEW CENTER

American politics is broken, with the far left and far right making it increasingly impossible to govern. This will not change until a vibrant center emerges with an agenda that appeals to the vast majority of the American people. This is the mission of The New Center, which aims to establish the ideas and the community to create a powerful political center in today's America.

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