Future of telehealth: Boom, or back to business as usual?

Michael A. Cassidy, Esq.

What is the future of telehealth? At the inception of the COVID-19 pandemic, in an article entitled "COVID-19 and the Rise of Telemedicine," the Medical Futurist reported:

"Telemedicine has not had the success it had hoped to achieve."

Now, just a few months later, telemedicine "might" be a new normal and multiple commentators and organizations, such as the American Medical Association (AMA) and McKinsey & Co., are touting the COVID-19 Public Health Emergency (PHE) as the long-awaited tipping point for the implementation of telehealth. Note some of the statements below; the underlining is mine.

- McKinsey & Co. projected that virtual visits could account for $250 billion dollars of annual healthcare business, or 20% of commercial, Medicare and Medicaid visits.
- The Medical Futurist reported in March 2020 that 82% of the providers had not used telehealth prior to the COVID-19 PHE but that 46% of surveyed providers are now using telehealth.
- McKinsey & Co. reported that telehealth accounted for 2% of total payments for the first quarter of 2019 but 7.5% of payments for the first quarter of 2020.

However, although there are strong indications of significant telehealth adoption, it is probably too early to confirm that progress and caution is appropriate. The projections are based upon assumptions and extrapolation of telehealth usage over a sustained time period. Healthcare commentators have made similar proclamations in the past that healthcare reimbursement would be saved by capitation, then by DRGs and WRVUs, then by the Triple Aim, then by P4P and now by Medicare for All and Telehealth. Some circumspection is advisable.

The two most significant absences with regard to these future comments are proof of quality and patient satisfaction, and input from the third-party payors. Without proof of improved quality due to either the nature of the telehealth visit or presumed improved access, it is unlikely that third-party payors will blindly continue to pay for telehealth visits, at least at the same reimbursement level as for in-person visits. In fact, an updated report from the Commonwealth Fund cited by Part B News indicates that in-person visits are already trending back up while telehealth is trending down.

Proof of quality will take a long time to provide. In fact, in my opinion, the scramble to allow telehealth access of any kind during the COVID-19 PHE without much in the way of data or control, will probably not provide sufficient information, or at least controlled information, to permit an informed judgment. Members of Congress are already seeking and proposing such studies:

- Rep. Robin Kelly, D-Illinois, has introduced the "Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act of 2020."
- Rep. Troy Balderson, R-Ohio, has introduced a bill calling on HHS and the Comptroller General of the United States to conduct studies and report to Congress on actions taken to expand access to telehealth services.
- The Senate Committee on Health Education Labor and Pensions (HELP) chaired by Senator Lamar Alexander, R-Tennessee, conducted hearings and called for several of the COVID telehealth waivers to be made permanent.

Obviously, none of these actions will be completed quickly, if at all.

Existing infrastructure problems

The rush to provide COVID telehealth services has temporarily obscured many of the structural telehealth problems or growth inhibitors. Telehealth is not a single platform paid for by a single provider and operated

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by only one entity, it is in fact a process involving all of the following:

1. State licensing of telehealth providers.

2. State law defining malpractice issues and, in the case of states which have telehealth practice statutes, defining the requirements to establish a physician-patient relationship.

3. Federal, state and commercial third-party rules regarding covered services, the permissible physical locations and geographic locations of services, and the required technology, i.e., real time versus store and forward, and other legal impediments, federal and state Anti-Kickback laws restricting the financial arrangements into which commercial companies and healthcare providers may enter.

4. Bandwidth and infrastructure availability for telehealth services (note that one of the key problems for instantly expanding telehealth services was the lack of internet access or sufficient interest access by both patients and providers).

COVID PHE Telehealth Waivers

In order to facilitate current COVID PHE telehealth visits, the federal government issued the COVID-19 Emergency Declaration Blanket Waivers for Healthcare Providers Action (which is available online at CMS), e.g: https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf.

- CMS expanded the categories of eligible providers that are authorized to bill for telehealth services from distant sites.
- CMS waived the rural geographic site restrictions so that telehealth was available in any location, not just rural and MUS areas.
- CMS waived the Medicare requirement necessitating the use of interactive telecommunication systems to furnish telehealth services (sometimes called real time or synchronous technology) that allowed audio only technology for certain services.
- CMS waived provisions related to telehealth medicine making it easier for telemedicine services to be furnished to a hospital patient through an agreement with an outside hospital.
- CMS waived its requirement for telehealth patients to be under the existing care of a physician.
- Many third-party payors temporarily waived co-pays.

- HIPAA, Stark and AKS relaxed enforcement.

Note that these federal waivers applied only to CMS programs, although many states waived licensing restrictions allowing telehealth services to be provided by a practitioner duly licensed in any other jurisdiction, in addition to the access provided by Federation of State Medical Boards (FSM) Interstate Licensing Compact. In addition to the state requirements, many commercial payors followed the CMS lead and relaxed their telehealth reimbursement requirements.

The key question in assessing the progress and staying power of telehealth will be what happens with these waivers. Review will come from two viewpoints. From just the volume basis, will either CMS or the other third-party payors rescind the waivers and put a brake on telehealth volume expansion simply because the new telehealth volume was additive rather than substitutive? Second, will the quality studies mentioned above impact telehealth?

On Aug. 4, 2020, CMS released the proposed 2021 updates to the Medicare Physician Fee Schedule, which included telehealth revisions to add more authorized services, include expanded technology and requested comments regarding allowing "direct supervision" on a virtual basis. This proposal also includes expanding the services for which non-physician practitioners (NPP) may be reimbursed, provided the expanded scope is authorized by state law.

One technical issue that never seems to be fully addressed in projections regarding telehealth is the "available bandwidth." There are numerous reports about state and federal agencies establishing portable hotspots to enable increased telehealth usage, and the lack of internet access in the remote areas where telehealth would help the most, although the number of patients would be smaller, has always been a problem. Furthermore, quality visits require quality technology at both the patient and the provider location, and that will be more difficult to provide when the patient sites become mobile.

State government impact

An ancillary set of issues with respect to the utilization of telehealth are those controlled by the state, i.e., state licensing of telehealth practitioners and the scope of practice regulations of the various state boards which both control what practitioners may practice in the state and what is required of those practitioners in order to establish a valid physician patient relationship.

Fraud and abuse

In one area, telehealth has indeed come of age; usage has reached the critical mass at which Medicare fraudsters have smelled opportunity. As I reported in a Medlaw Blog post in December 2017, the OIG has added telehealth usage to its compliance audit plan, and both federal and the state governments are now investigating telehealth-based billing schemes.

Conclusion

It is too early to tell whether the significant increase in telehealth visits, for both COVID testing and from the virtual visits for other services necessitated by state closure of practice and social distancing, will result in the continued expansion suggested by the commentators referenced in the beginning of this article or an opposite retrenchment to allow some time for review and analysis.

Mr. Cassidy is a shareholder at Tucker Arensberg and is chair of the firm's Healthcare Practice Group; he also serves as legal counsel to ACMS. He can be reached at (412) 594-5515 or mcassidy@tuckerlaw.com.