AIMEDALLIANCE

Telehealth in a Post-Pandemic World: Preserving Gains and Ensuring Access to In-Person Care

EXECUTIVE SUMMARY

I. Introduction

Telehealth is defined as the use of electronic information and telecommunications technologies that supports long-distance health care, health education, health administration and public health.[1] Telehealth provides meaningful health care access to patients who may not otherwise be able to meet with their health care provider in person.[2] In 2020, the COVID-19 pandemic, in particular, highlighted the need for such services. During the pandemic, many health care providers' offices closed, nonessential and elective surgeries and procedures were postponed, and patients were more fearful to leave the house even to receive health care services.[3] As a result, the demand for telehealth services increased exponentially, and remote appointments soon became a lifeline for patients and providers. In response, state and federal legislators acted swiftly to expand access to telehealth, removing longstanding barriers. As policymakers begin to plan for the future, it is essential to now consider which protections should be permanently enacted while also balancing the need to preserve access and appropriate incentives to in-person care when necessary.

On August 3, 2021, Aimed Alliance hosted a virtual roundtable discussion titled "Telehealth in the Post-Pandemic World: Preserving Gains and Ensuring Access to In-Person Care." Attendees included patient advocacy groups, health policy organizations, professional associations, and members of industry. The objectives of the meeting were to understand the telehealth landscape, assess provider and patient preferences, and consider ways to permanently preserve access to telehealth while still incentivizing in-person care. This report summarizes the discussion and recommendations.

II. Telehealth Level Setting: Barriers to Access and Pandemic-Driven Solutions

Aimed Alliance counsel, Stacey Worthy and Shruti Kulkarni, began the briefing by providing a landscape overview and analysis of telehealth, including advantages and disadvantages to patients and providers, current state and federal laws and regulations governing telehealth, impact of the COVID-19 pandemic on telehealth laws and regulations, and resulting trends. Benefits identified included expanding access to care for patients, promoting health equity, and reducing stigma.[4] For example, during the pandemic, telehealth allowed for continuity of care while mitigating the risk of exposure to COVID-19.[5] It is also beneficial to patients in rural areas or areas where there are no specialists nearby, as well as, those who may have a long commute, are not mobile, lack transportation, or cannot take time off of work.[6]

Like any approach, telehealth also has its drawbacks. Most notably, providers are limited in their ability to physically examine their patients or conduct tests, and therefore, telehealth may be unsuitable in situations in which a hands-on approach is required.[7] For example, a provider may miss symptoms that might have been noticeable during an in-person visit. Additionally,

while telehealth typically makes care more accessible, it can also deepen disparities due to lack of access to broadband and technology or lack of computer literacy.[8]

A. State Laws

Aimed Alliance counsel provided an overview of the patchwork of state laws governing telehealth coverage and reimbursement for Medicaid and private insurance plans. For example, state Medicaid programs vary on types of telehealth services they cover (e.g., real-time communication, store-and-forward, and remote patient monitoring).[9] Additionally, at least 43 states and the District of Columbia have parity laws requiring private payors to cover telehealth services comparable to coverage for in-person visits.[10] Some states also limit the types of providers that can offer telehealth services. For example, in Pennsylvania, only physicians, certified nurse midwives, and select mental health facilities can provide telehealth services. Many states and Medicaid programs have also placed limitations on originating sites (i.e., where the patient is physically located).[11] For example, the patient's home was often excluded as a reimbursable site.[12] Likewise, programs have restricted telehealth to rural or underserved areas, and providers were often prevented from writing prescriptions across state lines. Fortunately, many of these restrictions were eased during the pandemic. Since the public health emergency was declared, at least 22 states have expanded telehealth services in some way.[13]

B. Medicare

The Centers for Medicare and Medicaid Services (CMS) has also historically imposed restrictions on telehealth for Medicare beneficiaries. Prior to the pandemic, Medicare only reimbursed for telehealth services offered via video (and not audio only) and only via certain types of technology to ensure HIPAA compliance.[14] Like state Medicaid programs, CMS also restricted coverage to Medicare beneficiaries living in rural areas and placed limitations on originating sites (e.g., the patient's home was often not considered an originating site, and therefore, excluded from coverage).[15] During the pandemic, the federal government eased some of these restrictions, including allowing audio-only technology and use of common communication applications, such as Apple FaceTime, Zoom, and Skype.[16] Providers were also reimbursed for telehealth services rendered to patients located in their homes and beyond the designated rural areas.[17] Medicare also provided waivers that allowed providers to practice across state lines, and allowed reimbursement for new patients, not just established ones.[18] As a result of these flexibilities, more than one in four Medicare beneficiaries utilized telehealth services between the summer and fall of 2020.[19]

C. Impact of the Changes

Early in the COVID-19 pandemic, telehealth usage surged as consumers and providers sought ways to safely access and deliver health care. According to one report, in April 2020, overall telehealth utilization for office visits and outpatient care was 78 times higher than in February 2020.[20] While telehealth utilization has since stabilized, it is still at levels 38 times higher than before the pandemic.[21] Similarly, consumer and provider attitudes toward telehealth have improved since the pre-COVID-19 era.[22] Perceptions and usage of telehealth have only dropped slightly since the peak in spring 2020.[23]

However, it is important to note that these telehealth flexibilities also resulted in an increase in health care fraud against the Medicare and Medicaid programs.[24] For example, in September 2020, the U.S. Department of Justice (DOJ) announced that 345 suspects were indicted on felony health care fraud-related charges—the largest enforcement action in DOJ history.[25] Of the $6 billion in false and fraudulent claims associated with this case, more than $4.5 billion were in connection to telehealth.[26] One alleged scheme involved payment of "millions in kickbacks and bribes to acquire the durable medical equipment claims, which had been generated using aggressive telemarketing strategies in concert with fraudulent telemedicine involving bribed doctors who rarely spoke to the beneficiaries."[27] Similarly, in May 2021, the DOJ announced criminal charges against a telehealth company executive, physician, marketers, and medical business owners for COVID-19 related fraud, including for "sham telemedicine encounters that did not occur."[28] Policy changes moving forward will need to minimize the risk of fraud.

D. Survey Findings

Todd Bledsoe, Executive Director of Patient Engagement and Advocacy at Neurocrine Biosciences, presented the findings of a recent survey conducted from June 29, 2021, to July 2, 2021, on telehealth preferences.[29] The Harris Poll conducted the survey on behalf of Neurocrine Biosciences, and respondents included approximately 2,600 adults.[30] The survey found that many patients value telehealth, especially during the pandemic, but also seek to preserve access to in-person visits.[31] For example, since the start of the pandemic, 41 percent of individuals reported receiving health care services through telehealth while 72 percent received health care through in-person visits.[32] Additionally, 82 percent said that telehealth was a great option during the pandemic but generally preferred in-person visits.[33] Over one-third (37 percent) of respondents postponed a medical appointment until they could have an in-person visit.[34]

Respondents identified both strengths and weaknesses of telehealth. For example, respondents said telehealth advantages included not having to travel (55 percent), saving time (46 percent), and convenience (46 percent).[35] Respondents said the disadvantages of telehealth included the lack of an in-person physical exam (53 percent), the inability to monitor vitals (52 percent), and the possibility of missing a diagnosis (52 percent).[36] Among those who were dissatisfied with their telehealth experience, 42 percent listed technology issues as their top reason for the dissatisfaction.[37] Additionally, a key finding from the report was that the quality of care must be preserved for telehealth to succeed with patients , as 62 percent of respondents reported they were concerned they would not get the care they needed in a telehealth visit.[38]

Respondents also valued patient choice, with 87 percent stating that it was important to have the ability to choose whether they get to see their health care provider via telehealth or in-person; 72 percent stating that it is important to have access to a provider who offers both in-person and telehealth visits; and 70 percent stating they approve of telehealth as long as they can still see their health care provider in person once or twice a year.[39] These findings highlight the need to preserve access to both telehealth and in-person visits.

E. The Clinician's Perspective

David Charles, MD, the founder of Alliance for Patient Access, offered his perspective of telehealth, reflecting on nine years as the Medical Director for Telehealth at Vanderbilt University Medical Center. Dr. Charles started off by acknowledging the struggle to overcome telehealth barriers for many years and was pleased that the pandemic expanded access to telehealth, by removing many of the barriers that the federal government had put in place. He noted that approximately two million outpatient appointments are made at Vanderbilt each year, but at the height of the pandemic, that number fell by half. Luckily, half of those patients were able to be treated via telehealth.

Dr. Charles highlighted the importance of the decision on whether a patient should receive an in-person visit or a telehealth visit resting with the clinician and patient. In his view, if the clinician and the patient are comfortable with a telehealth visit, then the visit should occur virtually. If either the clinician deems it medically necessary, or the patient prefers to be seen in person, then the visit should default to in-person.

Dr. Charles provided context by offering some examples. First, he described a patient who had a liver transplant two years prior and lived four hours away from a medical center. During the pandemic, the patient was being monitored for his neuropathy (due to his illness and medications). Given the medical situation and the logistics of this patient, a telehealth visit was appropriate and conducted successfully. The patient was extremely happy and expressed his preference for telehealth moving forward. In his second example, Dr. Charles discussed a new patient with tremors, who preferred to have a telehealth visit. In this case, the tremors could be seen and diagnosed virtually, and again, a telehealth visit was considered appropriate. Next, Dr. Charles discussed a hypothetical patient for whom a telehealth visit would not be considered appropriate. The patient was a 50-year-old individual who had started experiencing weakness in his limbs, was dropping things, and had changes in his muscle mass. In this case, Dr. Charles concluded that telehealth would not be appropriate because an in-person physical exam was essential.

Finally, Dr Charles discussed his opinions on audio-only visits. While audio/visual visits allow clinicians to offer a more complete and thorough examination since they can see the patients and assess visual cues, he felt the change from audio/visual visits to audio only visits were necessary during the pandemic. Although he noted that he prefers audio/visual visits once the pandemic has ended, he did not disagree with the policy decision to permit audio-only visits given that not everyone has access to the technology needed for audio/visual virtual visit.

F. Policy Outlook

Aimed Alliance counsel provided an overview of legislative and policy activity. They expect that the current telehealth expansions will continue through the end of the public health emergency, which will likely last through the end of 2021.[40] However, many of the current flexibilities will require legislative or regulatory changes to make them permanent.[41]

They noted that on July 12, 2021, 35 Senators sent a bipartisan letter to the U.S. Department of Health and Human Services (HHS) and CMS asking for a "written plan and timeline for permanent administrative changes to Medicare rules governing the provision of telehealth" and a list of telehealth changes that will require Congressional action.[42] Additionally, they identified over 40 bills that have been introduced to make the current telehealth flexibilities permanent.[43] Many of the bills focus on similar protections including, expanding originating sites requirements to include the person's home, removing geographic limitations, parity of coverage and reimbursement, protecting interstate compacts, and providing broad discretion to CMS to determine coverage and reimbursement.[44] However, none of the bills currently include a provision that specifically preserves the patients' choice between telehealth or in-person care based on their preference or the providers' choice based on medical necessity.

Finally, CMS released the 2022 Physician Fee Schedule for Medicare, which includes a proposal to allow certain telehealth protections to remain in place until the end of 2023.[45] The rule includes the following proposals for telehealth services offered to patients receiving care for mental health condition or substance use disorders:

- Remove geographic restrictions and expand originating site requirements to include the beneficiary's home;
- Require an in-person visit within six months prior to the first telehealth service and at least once every six months thereafter;
- Allow for audio-only telehealth services for patients who do not have access to audio-visual technology or do not consent to video. However, the provider must still have access to audio-visual technology; and
- Allow for rural health clinics and federally qualified health centers to use telehealth.[46]

The comment period for the proposed rule closes on September 13, 2021.

III. Key Insights from the Roundtable Discussion

The meeting ended with a virtual roundtable discussion that featured lively engagement from a diversity of voices, including patient advocates, health policy experts, and health care providers. Participants shared telehealth experiences from their own perspective and from the perspectives of their stakeholders. A range of opinions show that the choice of telehealth and in-person care must be made by the patient and the provider.

A. Telehealth Is Beneficial for Many Patients and Providers

Multiple participants noted that telehealth has been beneficial to various patient and provider communities, especially during the pandemic. One participant said the response to telehealth from patients and clinicians in the epilepsy community has been overwhelmingly positive. She noted that telehealth services can be particularly beneficial to patients with epilepsy who are unable to drive because of the possibility of seizures. Another participant reiterated the importance of telehealth for those who cannot drive, especially during the pandemic considering that many are not comfortable taking taxis or using ridesharing apps. The ability to consult with providers from home reduces the patient's stress and the burden on caregivers.

One participant explained that patients with migraine disease have also been early adopters of telehealth because of the uncertainty of attacks and triggers of daily life. Another relayed that there has been a huge uptake of telehealth from women, especially those with mental illness and those with young children at home. She noted that telehealth visits have reduced stress and also destigmatized mental health conditions. Telehealth also has allowed women to make and keep their appointments while handling family obligations more easily. She noted telehealth can be used to assess bruises, bumps, and skin conditions. Additionally, she added that telehealth has been increasingly popular among women who are going through menopause because they can identify online providers, have more time to share their experiences and symptoms, and can identify a solution to help them through the peaks and valleys of menopause.

A participant also noted that telehealth visits have allowed practitioners and patients to understand each other more easily during the pandemic. Further, this participant noted that patients and providers must wear masks for in-person visits, which can make it difficult to communicate with each other.

B. Telehealth May Not Be Appropriate for Others

One participant noted that it may be necessary for some patients with progressive diseases to be seen in-office rather than exclusively via telehealth. She noted that a practitioner may not be able to assess the level of disease progression using telehealth. Another participant noted that telehealth also may not be appropriate for patients with eye diseases and conditions, such as glaucoma. A third participant stated that people living with pain may need to be assessed in person. Particularly, it may be difficult for the practitioner to assess weight loss or gain, vitals, gait, and ability to function. Additionally, people with pain may need to comply with agreements for opioid use that require certain components that can only be done in-person, such as submitting to drug tests.

Moreover, another participant noted that many patients have a strong preference for telehealth over in-person visits. Thus, she expressed concern that it may be difficult to get patients back into the office.

C. Patients and Providers Need Access to Both In-person and Telehealth Services

Many of the participants reiterated that any policy moving forward must facilitate both virtual and in-person options. They noted the importance of preserving provider and patient decision-making. One participant noted that clinicians are experiencing high levels of burnout from participating in virtual visits all day. Thus, she recommended that more providers become trained on telehealth to reduce that burden. She said "Being on a Zoom constantly all day is challenging. We know there is a nationwide headache specialist shortage in the country…opening up other providers to telehealth, making that more inclusive, expanding the ability of patients to see providers online but also in person—[that's an] issue that needs to be . . . addressed."

Another participant felt it was important for certain patients to have access to audio-only telehealth. She noted that patients without access to the internet may prefer audio only. Such patients may also be more suited for in-person visits.

One participant stressed that a major benefit of telehealth is access to rare specialists. She noted that there is currently a major rheumatologist and pediatric dermatologist shortage. As such, patients need access to providers in surrounding states. Interstate compacts could allow patients to be treated across state lines. At the same time, she also noted the importance of access to in-person visits given that many patients with dermatological conditions may not feel comfortable showing certain parts of their body on camera. As such, patients must have access to both in-person and telehealth visits.

IV. Recommendations

During the roundtable discussions, participants were asked to provide recommendations on preserving access to telehealth without disincentivizing in-person care. Their recommendations included the following:

- Preserve the ability of health care providers and patients to choose when telehealth or in-person care is right for them;
- Improve network adequacy (i.e., ensuring that there is a sufficient number of primary care providers and specialists within a health plan's network so that patients do not need to travel long distances);
- Encourage medical societies to create clinical guidelines to determine when it is appropriate for patients to be treated via telehealth versus in-person;
- Educate and train providers on best practices for telehealth visits;
- Encourage more providers to use telehealth as appropriate and recognize the instances in which care must be provided in person;
- Allow health care workers to come into the home to assist in practice of telehealth;
- Limit audio-only to patients who truly require it and potentially combine it with an in-person requirement; and
- Do not structure patient cost-sharing so that either telehealth or in-person is incentivized over the other.

Participants also expressed interest in working together to find common ground on the topics discussed at this event. They noted the importance of helping to inform patients, providers, and policymakers on this nuanced issue.

V. Conclusion

Since the onset of the COVID-19 pandemic, millions of people have benefitted from expanded access to telehealth, made possible by emergency measures from CMS. While not replacing in-person care in every instance, telehealth is expanding as a valuable option. Beyond the pandemic, federal and state policymakers will consider issues that impact access to both virtual and in-person care. While telehealth has proven to be beneficial and vital, there may be instances when providers determine in-person care is needed and when patients prefer in-

person care. The challenge for policymakers, therefore, is determining how to ensure comprehensive access to telehealth while still promoting access to in-person care when deemed medically necessary. Policymakers must determine the balance between these two forms of care and craft policies that allow virtual and in-person care to complement one another.

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[1] https://www.healthit.gov/faq/what-telehealth-how-telehealth-different-telemedicine
[2] *Id.*
[3] https://www.healthaffairs.org/do/10.1377/hblog20201006.263687/full/
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] https://www.health.harvard.edu/staying-healthy/telehealth-the-advantages-and-disadvantages
[8] https://www.healthaffairs.org/do/10.1377/hblog20200505.591306/full/
[9] For state Medicaid telehealth coverage laws, *see* https://www.cchpca.org/topic/overview/.
[10] There are varying levels of parity. Some states mandate coverage. For others, if a plan chooses to cover or reimburse for telehealth, then such coverage and reimbursement must be on par with that which is offered for in-person visits.
[11] For a list of states that have limits on originating sites, *see* https://www.cchpca.org/topic/originating-site/
[12] https://www.cms.gov/files/document/covid-final-ifc.pdf at p. 13-14.
[13] https://www.commonwealthfund.org/publications/issue-briefs/2021/jun/states-actions-expand-telemedicine-access-covid-19
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[43]https://mhealthintelligence.com/news/cures-2.0-includes-provisions-to-expand-telehealth-coverage-services; https://www.cchpca.org/federal/pending-legislation/
[44] https://www.cchpca.org/federal/pending-legislation/
[45] https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule
[46] *See* https://www.ruralhealthinfo.org/topics/rural-health-clinics (discussing provisions within the CARES Act that allow rural health clinics to use telehealth).