



Taskforce on Telehealth Policy (TTP) Findings and Recommendations

Latest Evidence: September 2020



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Executive Summary

Telehealth use rapidly expanded this year in response to the COVID-19 pandemic, meeting the urgent need to ensure access while limiting in-person encounters. Temporary telehealth and remote patient monitoring (RPM) policy changes at the state and federal levels have generated new evidence, practices and adaptations that question the need for many of the restrictions that had been in place prior to the pandemic. Six months in, patients, policymakers, caregivers, clinicians and other providers are generally supportive of maintaining the expanded availability of telehealth services and see it as a critical tool in advancing a well-coordinated, patient-centered and value-optimized health care system.

The Taskforce on Telehealth Policy (TTP) formed to assess early findings and experiences under the flexibilities granted by Congress and CMS during the public health emergency and build a consensus among diverse stakeholders on recommendations that will help realize telehealth's potential to drive well-coordinated, patient-centered and value-optimized care. These recommendations were also informed by more than 300 written public comments and a virtual townhall attended by nearly 1,000 stakeholders. In the end, the TTP found substantial agreement for keeping most—but not all—of the COVID-19 policy changes and exploring new ways to harness the rapidly evolving possibilities of telehealth.

Policymakers put in place extensive restrictions on the use of telehealth at a time when technology was less mature and use cases for it were more limited than today. Prior to the pandemic, assumptions about patient safety, program integrity (fraud, waste and abuse), quality and cost were cited as reasons for these restrictions. The TTP believes that data collected during the COVID period should help inform a reevaluation of telehealth policy and utilization, particularly in fee-for-service (FFS) Medicare. The TTP also finds that the move to value-based payment models with shared financial risk and responsibility for improving the health of a population should alleviate many of the previous concerns, as they allow clinicians and patients to choose the care modalities most appropriate to their needs and preferences.

The TTP acknowledges there are many ways telehealth is used by medical practitioners and accessed by patients. Telehealth as part of an integrated approach with in-person primary care and chronic disease management is different from telehealth used for urgent care or triage, which is different from telehealth used by hospitals for post-discharge follow-up. These are only some examples of the variation of telehealth usage. For purposes of this report, we discuss telehealth in a way that can apply to all of these practices.

The TTP broke into three subgroups: Patient Safety and Program Integrity; Data Flow, Care Coordination and Quality Measurement; and Effect on Total Cost of Care. Below is a summary of each group's findings and the overall recommendations of the TTP, which are delineated more deeply in the pages to follow.



Patient Safety: Telehealth can enhance patient safety by preventing care delays, reducing exposure to pathogens and minimizing travel needed for in-person care. Policymakers should fund research on telehealth best practices for patient safety and update existing patient safety event reporting structures to incorporate telehealth.

Program Integrity: Fraud occurs in all health care programs, but emerging artificial intelligence tools to audit claims and other data may have potential to make it easier to detect aberrations quickly. In the case of telehealth, investigators can uncover Internet Protocol (IP) addresses and other digital signatures (e.g., date/time stamps) to identify bad actors. Integrating these tools into existing enforcement mechanisms may eventually reduce telehealth program integrity risks below those involved with in-person care.

Quality: Telehealth is essentially a setting or modality of care, rather than a type of care. This means that it should be held to the same standards and quality measures as in-person care where possible and appropriate. In cases where the unique characteristics of telehealth dictate a change in a given measure, it should be adapted rather than reinvented or developed from scratch. Where evidence and standards of care allow, measure stewards should do so without altering standards and outcomes expected for services provided via telehealth.

Rules and protocols for data sharing and care coordination between telehealth and other care sites, and their implementation in the form of telehealth certification requirements, should be developed in alignment with standards for other settings and implemented in the form of telehealth platform certification requirements, with the goal of preventing telehealth from adding to the fragmentation and data silos that plague our health care ecosystem and maximizing the integration of virtual care.

As telehealth usage and digital connection continue to expand, patients and the entire health care ecosystem could benefit from tools that enhance care coordination and improve patient experience. “Virtual medical homes” emphasizing remote care, closer patient monitoring and integration of telehealth with in-person care is one potential example, as electronic access to care is a facet of successful patient-centered medical homes. Advancing the concept of a living digital document populated by all members of a patient’s care team that integrates information into a hub to support all care—virtual and otherwise—could also drive

higher quality and better outcomes. Policymakers should prioritize pilot testing these concepts.

Telehealth is well suited to improving the measurement of patients' experience of care. The current mail-based surveys suffer from low response rates, the inability to reach specific patient populations and slow feedback loops. Policymakers should leverage telehealth's uniquely digital aspects to improve timeliness, targeting and engagement in assessing patient experience, which is an essential aspect of quality.

Effect on Total Cost of Care: Prior to the pandemic, there was little data available to assess or project the cost effect of widespread access to telehealth in a FFS environment, particularly in Medicare. The temporary lifting of previous restrictions during the public health emergency allows an opportunity to begin doing so, albeit under extraordinary circumstances. A fuller picture will require understanding the effect on costs of COVID-induced care avoidance—among other factors unique to the current situation—and how those interact with greater utilization of telehealth during the pandemic. However, data collected to date indicate that the virtually unfettered availability of telehealth has not resulted in excess cost or utilization increases, even as supply and demand for in-person care has rebounded.

Behavioral health has been an exception. The TTP found anecdotal and data-driven evidence of significant increases in uptake of tele-behavioral health under the public health emergency. In part, the increase in demand may be related to the stresses and dislocation brought on by the pandemic, the lessening of social stigma some may attach to visiting in-person sites for this type of care or the reduction in regulatory barriers. Increased utilization of behavioral health services has the potential to decrease net costs and improve outcomes, as untreated behavioral conditions can contribute to greater physical health needs and overall spending. Again, additional evaluation is needed to better understand the impact on outcomes.

Early evidence also suggests that the expansion of telehealth has helped drive a reduction in the rates at which patients missed appointments (no-shows), which has been demonstrated to increase care plan adherence, improve chronic disease management and yield downstream cost savings. It has also increased the use of transitional care management services that improve outcomes and reduce readmissions, mortality rates and costs. Finally, some skilled nursing facilities (SNF) have deployed telehealth to resolve residents' health issues that would otherwise have prompted much more costly ambulance trips to hospitals and emergency departments (ED).

These data, while collected at a time of immense change and uncertainty, have not shown the large increases in net costs that some predicted broader access to telehealth services would bring. We won't know the true effect until the pandemic is over or until care has been adapted to the new reality post-COVID. Future permanent telehealth policy for public payers should be made on the basis of such available data and findings. As the volume of value-based payments increases across public programs, access to telehealth across payers should also increase toward the level currently seen in the commercial market if these tools prove effective in providing high-quality care that meets patient and payer goals.

Overarching Telehealth Issues: Policymakers should take additional steps to support safe, effective and equitable integration of telehealth into our health care ecosystem. This includes establishing a uniform taxonomy describing the full range of telehealth services and modalities that would aid in aligning standards, quality measurement, payment principles and program integrity guidelines. Policymakers must also promptly expand efforts to address deficiencies in broadband access and technology infrastructure, as well as trust and digital literacy. These gaps can increase health disparities and limit the dispersion of telehealth’s benefits. Finally, while the potential of telehealth to improve care and outcomes abounds, policymakers should not expect telehealth to singlehandedly resolve longstanding issues that exist throughout our health care system.

Policymakers should make permanent the following specific COVID-19 policy changes:

- Lifting geographic restrictions and limitations on originating sites.
- Allowing telehealth for various types of clinicians and conditions.
- Acknowledging, as many states now do, that telehealth visits can meet requirements for establishing a clinician/patient relationship if the encounter meets appropriate care standards or unless careful analysis demonstrates that, in specific situations, a previous in-person relationship is necessary.
- Eliminating unnecessary restrictions on telehealth across state lines.

Policymakers should look closely at the effect of expanding prescribing authority to telehealth, as authorized by the public health emergency. They should evaluate what policies and guidelines could be applied, to virtual prescribing to ensure patient safety and avoid adverse outcomes.

Policymakers should fully reinstate enforcement of Health Insurance Portability and Accountability Act (HIPAA) patient privacy protections that were suspended at the start of the public health emergency.



The TTP thanks everyone who helped us gather information and data and shared comments to aid our work. We hope these findings and recommendations guide policymakers and other stakeholders to a future where we see telehealth as the natural evolution of health care into the digital age.



Introduction

When COVID-19 emerged as a once-in-a-century threat to public health, the use of telehealth became indispensable to maintaining a functioning health care system. Federal regulatory and legislative actions, and those taken by private insurers expanded access to telehealth, and relaxed regulations to balance health care access with the need to avoid unnecessary physical contact.¹ Early data suggest telehealth also relieved travel burdens, reduced missed appointment rates, increased access to behavioral care, reduced skilled nursing facilities transfers to hospitals, boosted transitional care management and enabled patients to choose virtual visits across a much broader range of services. Consensus quickly emerged among many stakeholders, including some members of Congress and the Administration, that many telehealth policy changes should remain in place after the crisis.

“It’s taken this crisis to push us to a new frontier, but there’s absolutely no going back,” said

REPRESENTATIVE MIKE THOMPSON (D-CA)

“Telehealth is a proven and cost-effective way to get care out to patients, particularly during a crisis.... We know telehealth can be an essential bridge in delivering care, particularly during a crisis and today we are working to ensure telehealth continues in a post-Coronavirus world.”

Thompson, Welch, Johnson, Schweikert, Matsui Introduce the Protecting Access to Post-COVID-19 Telehealth Act, United States Congressman Mike Thompson, July 16, 2020.

¹ Refer to *Telehealth Policy Changes Made in Response to COVID-19*, page 25.

Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma to *The Wall Street Journal*.² “I think we need to do everything we can to support the health care system, make health care more accessible, make it more affordable—and telehealth is one powerful tool that can solve a lot of the problems that we have.”³

“We’re now aggressively looking at how to make the telehealth revolution a permanent part of American medicine,” wrote Health and Human Services (HHS) Secretary Alex Azar. “In many cases, well-meaning anti-fraud and privacy measures make it more difficult than it needs to be. There’s a reluctance to let Medicare pay for more telehealth on the grounds that this will drive up health care utilization, straining our health care system and the program’s budget. That kind of static thinking is one of the biggest problems in American health care. We shouldn’t stand in the way of delivering necessary health care services in the most convenient way possible—especially as our health care system shifts toward paying for outcomes rather than procedures.”⁴

Nevertheless, prior concerns about efficacy, appropriateness, fraud, waste and abuse and privacy that fostered previous policy restrictions still linger.

The Taskforce on Telehealth Policy (TTP) was formed to assess the changes occasioned by the pandemic and find agreement on recommendations that would maximize the availability of safe, high-quality and cost-effective telehealth services. Convened by the Alliance for Connected Care, the National Committee for Quality Assurance and the American Telemedicine Association, the TTP represents the perspectives of consumers, physicians, hospitals and health systems, insurers, telehealth platforms, quality measurement experts and federal government liaisons.⁵ The TTP divided into subgroups to address specific, often overlapping questions on:⁶

- Patient Safety and Program Integrity.
- Data Flow, Care Coordination and Quality Measurement.
- Telehealth Effect on Total Cost of Care.

Finally, this report was aided immensely by input from hundreds of health care stakeholders who shared their valuable insights on these and other topics through written comments, virtual meetings and our online Public Comment Town Hall. We hope the findings and recommendations we are sharing help guide policymakers as they chart the future for telehealth.

² *The Doctor Will Zoom You Now*, *Wall Street Journal*, April 26, 2020.

³ *The New Normal of Care Delivery*, *Health IT Leadership Roundtable*, July 2020.

⁴ *Trump Administration Aims to Keep Telehealth Revolution Here to Stay*, Azar, *USA Today*, July 31, 2020.

⁵ Refer to *Taskforce on Telehealth Policy Members*, page 34.

⁶ Refer to *Taskforce on Telehealth Policy Subgroup and Overarching Questions*, page 29.

Taskforce on Telehealth Policy Findings and Recommendations



Patient Safety and Program Integrity

PATIENT SAFETY FINDINGS

The goal for patient safety in a telehealth or in-person care encounter is the same. Care provided must not result in preventable patient harm or mortality. Telehealth patient safety includes ensuring access for patients with technology or digital literacy gaps. When a patient safety metric already exists for in-person care and is applicable to telehealth, apply it rather than create additional telehealth-specific metrics.

The Agency for Healthcare Research and Quality (AHRQ) recently released an issue brief that cited studies on telehealth and patient safety.⁷ Among the findings were:

- The evidence-base for telehealth is strong, especially for the remote management of chronic health conditions.⁸
- Systematic reviews confirm that telehealth improves health outcomes, utilization and cost of care for a host of chronic diseases, including heart failure, diabetes, depression, obesity, asthma and mental health conditions.^{9,10,11}
- For nonurgent complaints in primary care settings, diagnostic accuracy and the likelihood of diagnostic error appear to be roughly comparable in tele-diagnosis vs. face-to-face encounters.^{12,13}

The TTP did not achieve full consensus on all recommendations. For example, we found strong, but not unanimous, support for permanently lifting all controlled substance prescribing restrictions in telehealth. The public comments we received, in particular, provided anecdotal feedback suggesting that telehealth improved access, uptake and, potentially, outcomes for behavioral health for which controlled substances are often prescribed, such as medication assisted therapy for substance use disorder. This is reflected in the related recommendations below.

⁷ *Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis*, AHRQ, August 2020.

⁸ *The Impact of Telehealth care on the Quality and Safety of Care: A Systematic Review*, McLean et al., *PLoS One*, 2013.

⁹ *Telehealth for Acute and Chronic Care Consultations*, AHRQ, Totten et al, April 2019.

¹⁰ *Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews*, AHRQ, June 2016.

¹¹ *Improving Diagnosis in Health Care*, National Academies Press, 2015

¹² *How Accurate are First Visit Diagnoses using Synchronous Video Visits with Physicians?*, Ohta et al, *Telemed e-Health* 2017.

¹³ *Diagnostic Accuracy in Primary Care e-visits: Evaluation of a Large Integrated Health Care Delivery System's Experience*. Hertzog et al, *Mayo Clinical Proceedings*, 2019.



PATIENT SAFETY RECOMMENDATIONS

1. Policymakers, in partnership with clinical subject matter experts, should identify and recommend minimum standards for assessing and ensuring patient safety via telehealth care delivery and integrate them into existing safety standards.
2. Policymakers should integrate patient safety standards for in-person and telehealth care across health policy, adapting and supplementing existing safety standards, if needed. Policymakers should not layer new telehealth policies on top of existing in-person care regulations.
 - a. For example, there may be a need for standards to alert a telehealth patient that they need to seek in-person care, or to help a patient or their caregiver self-administer tests or perform other medical tasks.
 - b. Integrated patient safety standards should align with quality standards across health care policies, given the close relationship between safety and quality.
3. Congress should continue funding the research efforts of AHRQ and other organizations to identify what works—or what does not—in advancing telehealth patient safety, and should support development of best practices for telehealth as it does for other care sites.
 - a. AHRQ should clarify how to aggregate and analyze patient safety data to better identify improvement opportunities and publish research on telehealth encounter safety. For example, AHRQ could develop best practices and guidelines on optimizing patient safety in a telehealth encounter, as well as guidelines on safely transitioning to an in-person visit or a higher level of care.
4. Policymakers should update existing policy for in-person-care-related adverse patient safety events to incorporate telehealth, including collecting necessary information and data, as well as leveraging existing patient safety event reporting structures and the work of Patient Safety Organizations (PSO).
 - a. Integration of PSO patient safety event reporting could ensure the collection of standardized data on patient safety events in a telehealth encounter that result in serious injury or death.
5. Policymakers should carefully evaluate the experience of allowing prescription of controlled substances via telehealth during the pandemic, particularly for medication-assisted treatment of substance abuse disorders, and how continuing this policy can be done in a manner that protects patient safety and prevents overprescribing or abuse. This should include consideration of:



- a. How prescribing controlled substances in a telehealth encounter can comply with regulations and enforcement currently applied to in-person prescribing.
- b. The burden for compliance should be no greater than compliance with the same rules for in-person care.
- c. How policies should align with SUPPORT for Patients and Communities Act requirements for Medicare Advantage plans to use e-prescribing for controlled substances starting in January 2021.¹⁴
- d. How existing and emerging technologies, such as artificial intelligence and machine learning, may have potential to help detect and mitigate fraud and abuse.

PROGRAM INTEGRITY FINDINGS

While it is undoubtedly important to vigorously protect against fraud, waste and abuse (FWA) throughout health care, including in telehealth, arbitrary telehealth restrictions are not a justifiable or viable program integrity strategy. Arbitrary restrictions will not deter unscrupulous actors who will continue to engage in long-standing fraud schemes associated with medical equipment, opioids, compounding pharmacies and other areas.

The most effective approach to aggressively fighting FWA for both in-person and telehealth care is to leverage sophisticated technology tools that can enhance existing program integrity enforcement efforts, and also to drive better collaboration with health care stakeholders.

In crafting our recommendations, we considered common types of FWA that can occur during an in-person patient visit, including claims for medically unnecessary care, billing for services that were never delivered, illegal kickbacks and inappropriately coded claims. Policymakers can aggressively mitigate FWA risk in all these common types through adoption of TTP recommendations regardless of modality.

**KATE BERRY,
SENIOR VICE PRESIDENT
OF CLINICAL INNOVATION,
AMERICA'S HEALTH INSURANCE PLANS**



"When we're thinking about program integrity, we need to be thinking about patient safety, it's not just fraud and abuse. It's also the patient at the core and we want to make sure that what we're doing is safe and has value."

¹⁴ SUPPORT for Patients and Communities Act, United States Congress, 2018.



PROGRAM INTEGRITY RECOMMENDATIONS

1. Congress should direct and fund enforcement agencies to harness available and emerging technologies. As part of their anti-fraud efforts, federal and state governments should foster the development of strategies that can help prevent abuse by using sophisticated analytic and artificial intelligence tools that can detect fraudulent behavior, and audit claims on the back end to uncover aberrations, for example. Telehealth enables payers to monitor IP addresses, date/time and other digital signatures to help identify bad actors. This may facilitate fraud detection and eliminate the need to physically check in-person locations and patients.
 - a. Under the Health Care Fraud and Abuse Control (HCFAC) program, the HHS Inspector General (IG) and CMS have extensive program integrity policies and procedures in place to address FWA and improper payments. HHS should invest in innovative enforcement strategies, employ private sector best practices and leverage predictive analytic methods and emerging artificial intelligence and predictive analytics to fight FWA in telehealth.
 - b. The agencies tasked with protecting Medicare, other health programs, and ultimately, patients and taxpayers, must be appropriately resourced to maximize and incorporate technologies and strategies to uncover aberrations through claims audits and enhance investigations with digital forensics tools.
 - c. These actions may have potential to improve the ability to detect fraud, waste and abuse, and could potentially lower telehealth program integrity risks below the amount seen with in-person care.
 - d. Policymakers must protect patient privacy in every telehealth FWA mitigation effort.



2. Congress does not currently need to create new programs to address telehealth FWA, but instead should require HHS to integrate telehealth into existing FWA efforts.
 - a. HHS should ensure coordinated, efficient and effective enforcement within and across HCFAC, the IG, the CMS Center for Program Integrity, CMS contractors such as Zone Program Integrity Contractors, Medicaid Fraud Control Units and the Federal Bureau of Investigations.
 - b. HHS should ensure that these groups continue to develop and enhance telehealth FWA detection and mitigation strategies beyond telemarketing-oriented durable medical equipment fraud, and integrate such efforts with in-person and existing HCFAC workstreams.
 - c. HHS should provide guidance on the application of newly integrated policies to help payers, clinicians and other providers understand and comply. HHS should partner with the Medicare Learning Network and private sector stakeholders to maximize the effectiveness of this education.
3. Since previous IG fraud reports related to telehealth make it easier to commit traditional fraud, HHS should closely monitor this and examine further ways to deter traditional fraud if there is evidence telehealth accelerates it, especially in light of known experience with issues like durable medical equipment.



Data Flow, Care Coordination and Quality Measurement

DATA FLOW AND CARE COORDINATION FINDINGS

By virtue of its digital, direct-to-patient and portable nature—and its use across a wide range of specialties and sites—telehealth is well positioned to help accelerate the move to a more coordinated, interoperable experience for patients, clinicians and other providers. To do so, the health care community needs standards, guidance and best practices on care management, data flow and documentation that will establish a degree of consistency across all care sites. Done right, these guidelines will encourage telehealth “mobility” and maximize its potential, while also smoothing the path for adoption by clinicians and other providers.

Delivering high quality, well-coordinated care to patients at home through telehealth is an important goal. Older adults and people with complex care needs want to live as independently as they can for as long as they can. Telehealth has the potential to improve access to and quality of care, while reducing strain on family caregivers.

Remote patient monitoring (RPM) is a multi-faceted, rapidly evolving subset of telehealth that brings unique data flow and care coordination challenges and opportunities. RPM, unlike most other forms of telehealth, is primarily asynchronous and may require evaluation of inbound data by a clinician. In some instances, RPM involves sharing of discrete services and expertise from one location to another, enhancing system capacity and performance and bridging care gaps. In others, it is part of a holistic treatment plan, enabling more frequent, accurate monitoring and consultation between patients and providers without requiring individuals to leave the safety of their homes. This is particularly important for vulnerable populations.

Increasingly, RPM can entail receipt of data from wearables and other devices that may not be related to a specific diagnosis or care plan but may be helpful in assessing and addressing health concerns. RPM has the potential to fill gaps between patients’ visits with their doctors and to leverage the rapidly expanding array of tools that augment patient-generated health data.

There are also new opportunities for telehealth to support improved care coordination and data flow. One is through the development of “virtual medical homes” that provide patient navigators to coordinate care and follow-up for patients receiving remote services, while ensuring integration



into the larger health system. Virtual medical homes could decrease transportation costs and burdens, increase access to care (particularly for those who are in rural settings or mobility challenged) and drive down no-show rates.

Another is to begin moving toward a standard by which all members of a patient’s care team—not just those delivering care via telehealth—update and share a living, virtual, care coordination document. While interoperability is a long-standing goal that faces many challenges, there may be ways in which telehealth can uniquely contribute to addressing some of these challenges and drive adoption of a more patient-centered approach to coordinating individuals’ treatment across their care team. If nothing else, many telehealth visits involve the two-way, digital exchange of data and information in a fashion that can reasonably be expected to contain opportunities to share data and records more interoperably.

DATA FLOW AND CARE INTEGRATION RECOMMENDATIONS

1. Policymakers and stakeholders should develop and document clear data sharing standards and guidelines that send a signal to clinicians, other providers and vendors about data transmission and interoperability expectations. These standards and guidelines should become the basis for telehealth platform certification requirements that are aligned with data sharing and documentation guidelines for other care settings.
 - a. These should include provisions that encourage integration of telehealth-related data and care records with all other patient information and strong patient privacy and security criteria to ensure compliance with HIPAA and a requirement to ensure patients have access to their data and that platforms share patients’ data promptly at their request. The goals should be to facilitate interoperability, lower the barriers to telehealth integration and facilitate outcomes analyses that leverage telemedicine data registries.
 - b. The work should build on existing standards and 21st Century Cures Act data sharing and anti-data blocking legislation¹⁵ and regulations.¹⁶ While the standards and guidelines should serve as a floor of minimum expectations, policymakers should also describe an optimum level of capabilities in these areas.
 - c. Policymakers should immediately convene relevant third-party entities such as (but not exclusive to) the Interoperability Standards Advisory, Health Level 7, CARIN Alliance, NCQA and radiology’s Digital Imaging and Communications in Medicine (DICOM) to develop the above, with input from vendors, patients, payers, clinicians and other providers, quality measurement entities and other relevant stakeholders.

¹⁵ *The 21st Century Cures Act*, December 13, 2016.

¹⁶ *Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers*, Centers for Medicare and Medicaid Services, May 1, 2020.



2. CMS should develop and pilot a program that empowers and supports patients receiving care remotely. Patients opting to partake in this virtual medical home model would have access to designated patient navigators and other tools to maximize data sharing, care coordination, patient experience and outcomes. The program should be designed to complement and enhance any existing care coordination or patient-centered medical home services in place and to fully integrate remote care into the health care system. These wrap-around services could have the most impact in publicly subsidized managed care arrangements, such as Medicare Advantage, managed Medicaid and Exchange plans.
 - a. Community health workers or community-based organizations with particular knowledge and expertise in a given region or population could be enlisted to provide this function.
 - b. Higher levels of services would be available to those with more complex needs or challenges.
 - c. To make such a model feasible, policymakers must align payments, care management protocols, penalties and other incentives across programs and payers, and clearly enumerate responsibilities of each party.

3. The recent CMS Interoperability Rule moves payers toward adopting FHIR-based standards. In coordination with this effort, funding should be allocated to efforts that promote a shared, living, virtual, patient-centric care plan among all members of a patient’s team—such as the FHIR CarePlan—and away from siloed, encounter-based documentation. Of course, the shared care plan will require numerous patient consent considerations that must remain at the forefront, especially when it comes to protected health care information like behavioral health, substance use disorder information or HIV, for example. A pilot test should be conducted to refine and advance the concept.
 - a. Based on past experience, strong accountability models are essential to driving this kind of coordination.
 - b. The virtual plan should not restrict an individual provider’s ability to maintain a plan for their portion of the patient’s care, but encourage the use across providers of a dynamic master care plan that accounts for all of the patient’s medical interactions.



QUALITY MEASUREMENT FINDINGS

The quality enterprise should prioritize the use of existing standards and measures when evaluating the quality of care provided by telehealth. Where this is not feasible, measures should be adapted according to clinical guidelines, rather than reinvented to conform to the methods unique to telehealth. For example, telehealth encounters can require getting labs before a visit, ensuring that patients can use and are comfortable with the technology during the visit, and helping patients navigate needed follow-up remotely after the visit. To this end, NCQA responded to the lifting of telehealth restrictions during the COVID-19 pandemic by updating 40 HEDIS® measures to deem services provided by telehealth as equivalent to in-person care for purposes of measure compliance.¹⁷

Policymakers should carefully consider the capabilities, limitations and requirements of telehealth as a site of care when measuring the quality of a telehealth encounter, as would be done with any other site. Measurement should focus on whether a telehealth encounter delivers what the patient needs, improves health outcomes, provides an experience the patient can interact with appropriately and integrates with the patients' overall health care. Moreover, stakeholders should view telehealth as part of a continuum of encounters between patients and clinicians that are coordinated among varying sites, not stand-alone events.

Early findings from COVID-era experience suggest that telehealth may reduce missed appointment (no-show) rates in comparison with in-person visits. In addition, telehealth may have a positive impact in supporting family caregivers, as they often play a critical role in patients' health and well-being. Measure stewards and policymakers should work to quantify each of these potential benefits, where possible, as quality measures are adapted for telehealth, consistent with the goal of improving the patient and family caregivers' experiences, integrating health and social supports and understanding patients' goals and preferences.

Measuring quality provided via RPM is another area that requires attention. Any standards and measures related to RPM should be designed to capture the tangible impact of this modality's effectiveness, efficiency and closer monitoring of chronic conditions that can prompt earlier interventions to reduce costly exacerbations, improve outcomes and patient and family caregiver experience and ensure data flow in a way that maximizes its impact.

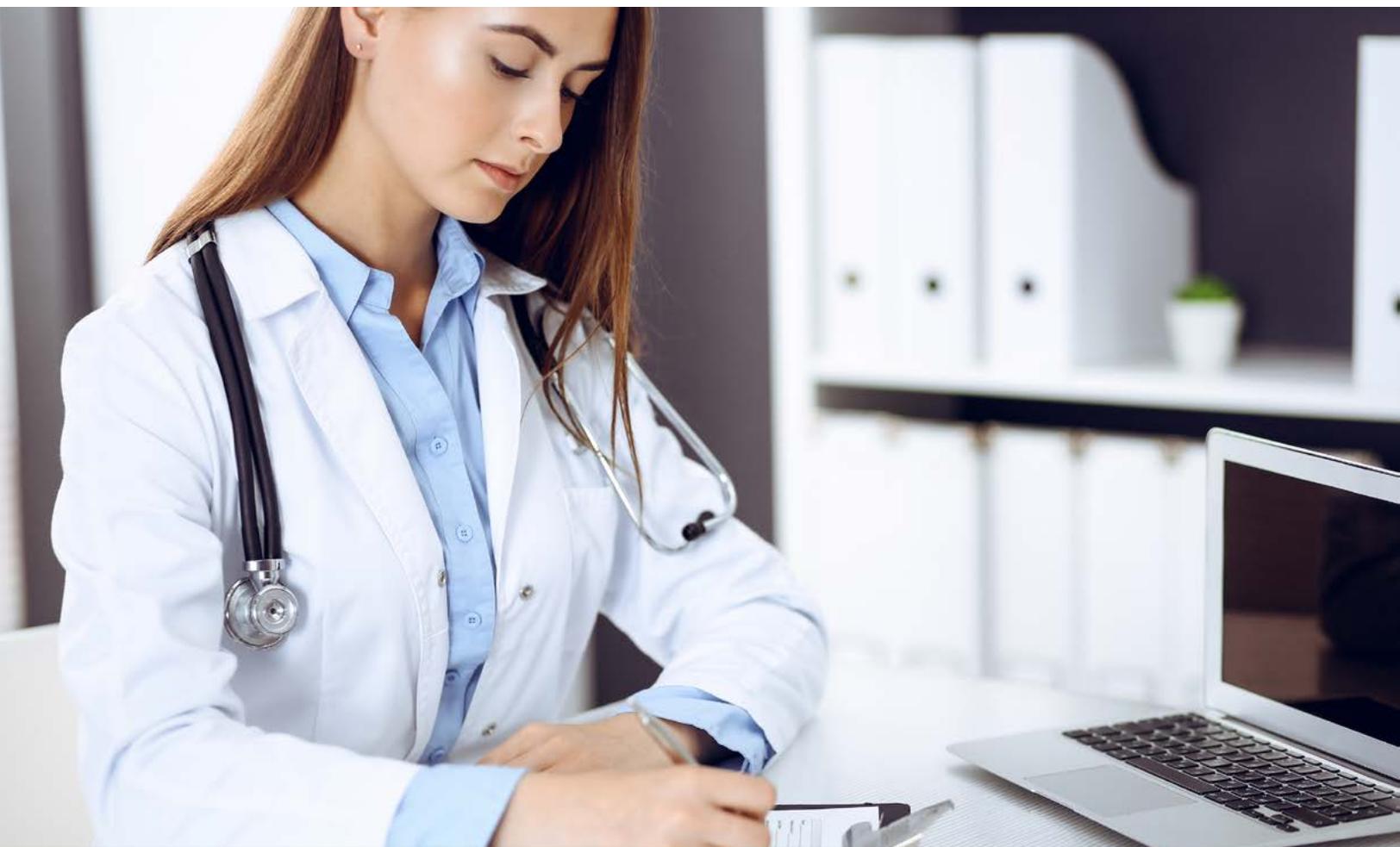
Telehealth also offers a "leap forward" opportunity for patient experience measurement. Because the initiation, completion and follow-up for a telehealth visit often occur digitally, there exists the possibility of assessing patient experience in a more real-time, clinician and other provider-specific fashion that improves response rates and provides faster, more meaningful feedback than current mailed paper surveys. While some existing patient experience metrics may apply equally to telehealth, others will not. This should be a factor in developing and implementing patient experience measures for remote encounters.

¹⁷ HEDIS, the Healthcare Effectiveness Data and Information Set, is a registered trademark of NCQA.



QUALITY MEASUREMENT RECOMMENDATIONS

1. Measure stewards should carefully and thoughtfully review all measures individually to determine the need for telehealth adaptations.
 - a. Review should consider how quality measurement could account for telehealth's unique impact on quality, safety, cost effectiveness, access and outcomes.
2. CMS should pilot a patient experience survey linked to telehealth encounters for all types of care, leveraging telehealth's uniquely digital aspects to improve timeliness, targeting and engagement.
 - a. Lessons learned should help update patient experience measurement across settings to improve response rates and provide faster, more targeted feedback.





Telehealth's Effect on Total Cost of Care Findings

Among the greatest barriers to broader telehealth adoption are assumptions among policymakers that allowing greater telehealth access will lead to higher utilization and costs. This opinion is especially prevalent for FFS Medicare. Recent data provided to the TTP challenge some of these assumptions.

A small silver lining of the pandemic has been the generation of first-ever Medicare FFS data that allows budget analysts, including the Congressional Budget Office (CBO), the Office of Management and Budget and the CMS Actuary, to begin to assess telehealth's impact on Medicare more accurately.

Policymakers will, of course, want further analysis of how much COVID-induced care avoidance may have contributed to telehealth's impact on utilization during the pandemic. However, data generated from provider organizations and the federal government to date show that total health care utilization remained steady during telehealth's expansion and did not substantiate concerns about supply-induced demand.

CONGRESSIONAL BUDGET OFFICE TELEHEALTH ESTIMATES

Traditional Medicare stands out from other major insurers and value-based payment models that use telehealth for patient care and savings. This is largely because the CBO says that telehealth dramatically increases utilization and costs. CBO does not count potential savings, for example from avoided SNF transfers, reduced readmissions, better chronic disease management and avoided urgent care visits. Because Congress often requires offsetting new spending, CBO has great influence. However, CBO's assumptions have led to substantially overestimated telehealth costs. In 2001, after Congress introduced telehealth into Medicare, CBO projected the cost to be \$150 million in the first 5 years, or \$30 million a year.¹ In fact, over the first 14 years, Medicare spent only \$57 million—a third less in almost triple the time.² CBO explained its hesitancy in 2015, saying, "Because Medicare coverage of telemedicine is limited, CBO does not have extensive data that would help project how expanding such coverage would affect federal spending."³ CBO does not use Veterans Administration and Department of Defense data, both of which use telehealth extensively, because they are "closed systems."

¹ H.R. 5661 Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, CBO, September 2001.

² Telemedicine Fans Point to CBO's History of Cost Overestimates, Politico, December 2014.

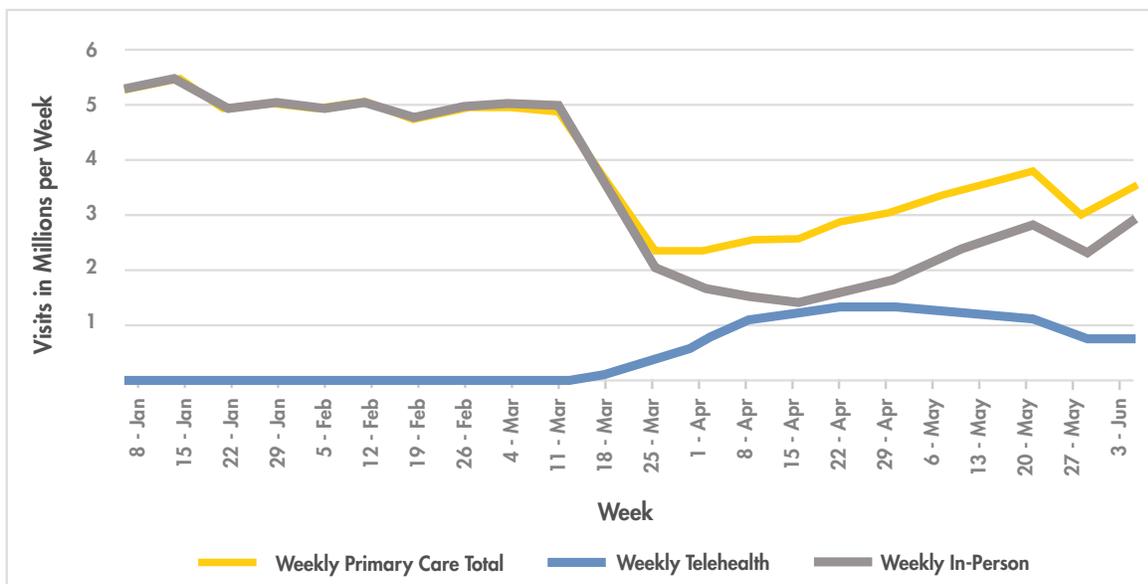
³ Telemedicine, CBO, July 2015.



For example, an HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) Medicare FFS telehealth report found that from mid-March through early July more than 10.1 million traditional Medicare beneficiaries used telehealth.¹⁸ That includes nearly 50% of primary care visits conducted via telehealth in April vs. less than 1% before COVID-19.

However, the net number of Medicare FFS primary care in-person and telehealth visits combined remained below pre-pandemic levels. As in-person care began to resume in May, telehealth visits dropped to 30% but there was still no net visit increase. The effects of the COVID-19 pandemic on patients seeking or avoiding care still need further analysis, but these data suggest that telehealth substituted for in-person care without increasing utilization.

Figure 1. Primary Care Visits for FFS Medicare Beneficiaries (visits in millions per week)



Source: Medicare claims data up to one 3rd, available as of June 16.

Other sources mirror ASPE’s findings. The U.S. Department of Veterans Affairs researchers found that, from March to May 2020, a 56% decline in in-person visits was partly offset by a two-fold increase in telephone and video visits.¹⁹ At least during that period of the pandemic, telehealth replaced in-person visits but did not increase overall utilization.

The TTP obtained initial findings from health systems and independent practices across the country, including Johns Hopkins, Stanford Health Care, Ascension, Intermountain Healthcare, Nemours Children’s Health System, University of Rochester, Northwestern and Aledade. The TTP also received input from the American Academy of Actuaries’ Telehealth Subcommittee, an advisor to the HHS Secretary, a former Medicare leader and a former Congressional Committee staffer who dealt regularly with the CBO. Using these data, we narrowed our focus to five key topics that can impact costs.

¹⁸ Medicare Beneficiary Use of Telehealth Visits: Early Data From the Start of the Covid-19 Pandemic, HHS Assistant Secretary for Planning and Evaluation, July 2020

¹⁹ Reduced In-Person and Increased Telehealth Outpatient Visits During the COVID-19 Pandemic, Annals of Internal Medicine, August 2020.



1. Substitution of in-person care.
2. Preventing more costly care.
3. Lower no-show rates.
4. Greater transitional care management.
5. Lowering skilled nursing facility transfers.

Substitution Effects. It is essential to distinguish between the extent to which telehealth serves as a substitute for in-person care as opposed to an add-on. One study estimates that virtual care could substitute for up to \$250 billion of current U.S. health care spending,²⁰ and the emerging data from the pandemic shows this could be correct. It is still too soon for large-scale, academically rigorous analysis of what is happening that properly discount pandemic effects, but the evidence from March to July is promising for telehealth.

Data gathered by the TTP indicate that telehealth largely substituted for in-person care and did not increase the total number of visits. Again, policymakers will want further analysis of the separate phenomena of cost related to COVID-induced care avoidance and cost related to widespread access to telehealth. However, as with ASPE, health systems surveyed by the TTP found that telehealth simply represented a change in care delivery modality with steady overall utilization. Total visits, including in-person and video, never went above pre-pandemic levels, even as clinics reopened to in-person care broadly across the health system.

Preventing More Costly Care: Telehealth facilitates access to health care for individuals who might otherwise skip or avoid important services. It also allows care delivery more quickly and efficiently in lower cost settings. The TTP found evidence that telehealth can help reduce more costly urgent and ED care, as well as use of costly and often overused services such as imaging.

- Ascension Health found that, from March to May of this year, nearly 70% of patients would have gone to either urgent care or the ED had they not had access to virtual care. These patients would have used more costly options without access to telehealth.²¹
- Nemours found that 67% of parents who used its 24/7 on-demand virtual care service before COVID-19 reported they otherwise would have visited an ED, urgent-care center or retail health clinic had telehealth not been available.²²

²⁰ *Telehealth: A quarter-trillion-dollar post-COVID-19 reality?*, McKinsey and Company, May 2020.

²¹ *Ascension Task Force on Telehealth Policy, March-May 2020.*

²² *Analysis of a Pediatric Telemedicine Program, Vyas et al, December 2018.*



- A pre-COVID-19 Anthem study of Medicare Advantage claims data for acute and non-urgent care utilization found savings of 6%, or \$242 per episode of care costs, by diverting members to telehealth visits who would have otherwise gone to an ED. The study also found less use of imaging, lab tests and antibiotics.²³
- In a pre-COVID-19 study of 40,000 Cigna beneficiaries, the 20,000 beneficiaries who used the MDLive telehealth platform had 17% lower costs when compared with non-virtual care. Virtual care users also experienced a 36% net reduction in ED use per 1,000 people compared to non-virtual care users.²⁴

No-Show Rates: Policymakers need to consider telehealth’s impact on no-show rates. Missed appointments decrease care plan compliance, which can lead to more expensive care needs. In 2012, CBO determined that prescription drug legislation cost estimates must account for the offsetting effects of medication adherence.²⁵ Telehealth’s similar offsetting effects on no-show rates and better care plan adherence contribute to downstream cost savings and are thus important cost factors. For example, in diabetes care management, routine visits can help prevent long-term, costly effects.

Health systems and clinician practices consistently report lower no-show rates with telehealth, especially in behavioral care, where telehealth removes the stigma of visiting a behavioral clinic. For example, the baseline no-show rate for psychiatry services is between 19% and 22% of appointments—while MDLive reports no-show rates of only 4.4% – 7.26% for its behavioral health telehealth visits.²⁶ Dr. E. Ray Dorsey, MD, MBA, professor of neurology and director of the Center for Health and Technology at the University of Rochester Medical Center, commented that patients are more likely to show up to virtual appointments—with no-show rates down about 10% during the pandemic. For the Marshfield Clinic, office visit no-show rates pre-COVID-19 were roughly 5%; they dropped to 3.8% with telehealth during COVID-19.

Improved no-show rates are likely due to telehealth’s convenience, especially its impact on travel burdens that create barriers to care in accessing transportation, taking time off from work and finding childcare. In 2018, CMS estimated that telemedicine saves Medicare patients \$60 million on travel, with a projected estimate of \$100 million by 2024 and \$170 million by 2029.²⁷ CMS also noted that estimates tend to underestimate telemedicine’s impact. Higher projections estimate \$540 million in savings by 2029.

**CHRIS MEYER,
DIRECTOR OF VIRTUAL CARE,
MARSHFIELD CLINIC:**



“We saw many more farmers getting behavioral health services during COVID that didn’t before. When we talked to them, they were brutally honest, “There’s no way in heck I’m going into a building that says behavioral health, but if I can do it on my iPad at home, I’m okay doing it.”

²³ *Telehealth Eliminates Time and Distance to Save Money, Healthcare Finance, October 2019.*

²⁴ *At Cigna, Telehealth Reduces Patient Costs and ER Visits, and Boosts Use of Generic Rx, Healthcare IT News, November 2019.*

²⁵ *Offsetting Effects of Prescription Drug Use on Medicare’s Spending for Medical Services, CBO, November 2012.*

²⁶ *Research Reveals Reasons Underlying Patient No-shows, ACP Internist, February 2009.*

²⁷ *Medicare and Medicaid Programs; Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit, Program of All-Inclusive Care for the Elderly (PACE), Medicaid Fee-for-Service, and Medicaid Managed Care Programs for Years 2020 and 2021, Centers for Medicare and Medicaid Services, November 2018.*



Transitional Care Management (TCM): While the TTP did not have time to collect enough data to fully analyze TCM, we received anecdotal evidence that TCM code billing increased during COVID-19. This suggests that clinicians, other providers and patients are more robustly utilizing TCM services. Previous analysis has suggested that increased TCM usage can lower readmissions, thereby reducing health care costs.

TCM service use increased from roughly 300,000 claims during 2013, the first year of TCM services, to nearly 1.3 million claims in 2018. This resulted in significantly lower readmission rates, significantly lower mortality, and significantly decreased health care costs.²⁸ The analysis also found that TCM use is low when accounting for the number of Medicare beneficiaries with eligible discharges. CMS cited this study in its 2020 physician fee schedule rule, noting that increasing medically necessary TCM utilization could positively affect patient outcomes.²⁹ Readmissions are particularly detrimental for patients and hugely costly to providers and payers—in 2019 roughly 83% of hospitals incurred readmission penalties.

Lowering Skilled Nursing Facility (SNF) Transfers. SNF patient hospital readmissions cost Medicare over \$4 billion each year. The TTP received data from Third Eye Health, a platform that triages patients via telehealth who may need to be transferred to the hospital, showing that their consultations from March–July successfully treated patients in SNFs at an overall rate of 91%, including for high-cost falls with injury (84.79%), shortness of breath (66.67%) and acute or chronic pain (95.96%). While much more evidence needs to be collected, the TTP believes telehealth in SNFs may decrease readmissions, as well as hospitalizations and ED visits, yielding significant savings.³⁰

Telehealth and RPM's impact on reducing strain on the estimated 41 million family caregivers also merits consideration. In 2017, family caregivers furnished \$470 billion worth of care, more than total out-of-pocket spending on health care that year (\$366 billion) or the total spending for all sources of paid long-term services and supports, including post-acute care in 2016 (also \$366 billion).³¹

Telehealth and RPM also create opportunities for additional communication and information sharing between patients, caregivers and clinicians. Accelerating adoption of value-based payment models, which have shared financial risk to incentivize prevention, chronic disease management and efficiency, can integrate telehealth.

²⁸ *Changes in Health Care Costs and Mortality Associated With Transitional Care Management Services After a Discharge Among Medicare Beneficiaries*, Bindman et al, September 2018.

²⁹ *Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies*, Centers for Medicare and Medicaid Services, November 2019.

³⁰ *Use Of Telemedicine Can Reduce Hospitalizations Of Nursing Home Residents And Generate Savings For Medicare*

³¹ *Valuing the Invaluable*, AARP, 2019.



Finally, debate will continue over appropriate telehealth payment amounts, but key principles can help focus these discussions. Telehealth should be seen as neither inherently driving nor reducing costs. Similarly, payers should have flexibility in rates and sites, based on different markets and different situations, and should retain the ability to innovate with product offerings that reward value-based providers. It is in everyone's interest to ensure that telehealth services are reimbursed at a rate that reflects the cost of providing these services and the value that they bring as part of the overall care experience. Appropriate reimbursement and access to telehealth services will allow patients to utilize these services where they and their care team feel it is both clinically appropriate and the best possible way of receiving care.

**RICARDO MUNOZ, MD,
CHIEF, DIVISION OF CARDIAC
CRITICAL CARE MEDICINE &
EXECUTIVE DIRECTOR, TELEMEDICINE,
CHILDREN'S NATIONAL HEALTH SYSTEM:**



"On the fee-for-service side, the technical fees paid to in-person and telehealth visits should be commensurate with the cost and benefit of providing the service. Otherwise, institutions may favor physical visits over telehealth for reimbursement purposes."





Cost Recommendations

1. Telehealth services should be reimbursed based on a thoughtful consideration of the value provided and the cost of delivery—as is done with in-person care. Flexibility on the use and reimbursement of these services is essential to maximizing the benefit to patients and the system at large.
2. When analyzing and discussing telehealth costs, policymakers should take a wider view and incorporate costs to patients and family caregivers, clinicians and other providers, and payers. These costs could—and should—include avoided transportation costs, time spent scheduling, preparing for or waiting for a visit, missed work, child/elder care, missed appointments, and technology/infrastructure costs. Although a change in care modality may create new costs, policymakers should not examine these costs without considering “baked in” in-person costs.
3. Accurately assessing the true value – including the cost and quality – of telehealth utilization will require that policymakers focus on evidence of its effectiveness and its ability to meaningfully increase access to care, not previously-held assumptions. Data from the current public health emergency are a first look at the effect on Medicare costs of lifting telehealth restrictions and it does not, at this writing, reflect excessive or unnecessary utilization. However, long-term conclusions and policies based on costs and outcomes in Medicare can only be drawn from data derived during the relatively normal conditions that follow the pandemic. Increased behavioral health utilization during the pandemic may provide a good example of meaningful increased access that has potential to improve outcomes and avoid future unnecessary and costly utilization. This will require further investigation.

**MARGARET E. O’KANE,
PRESIDENT, NCQA**



“Value-based arrangements with providers and plans at risk create the flexibility to design models that utilize telehealth where and when it can help improve care and outcomes.”



Overarching Issues

OVERARCHING ISSUES FINDINGS

Telehealth demonstrated during the COVID-19 public health emergency that it can improve access, safety, convenience, efficacy and patients experience of care. Telehealth is the natural evolution of health care into the digital age—it is not a different type of care, but a different site of care. As such, we should not hold telehealth to higher standards than other care sites, and we should trust clinicians providing telehealth services to triage patients needing a higher level of care or in-patient care, as we do in other care settings. As is done in other care settings, patients' preference for obtaining care in-person vs. telehealth should be respected

This raises important questions about many previous telehealth restrictions, such as prohibiting reimbursement for visits originating in patients' homes and allowing limited types of conditions and providers to utilize telehealth under traditional Medicare, such as behavioral clinicians and physical therapists. Many—but not all—policy changes that temporarily lifted restrictions during the pandemic should become permanent. There are better ways to address FWA concerns and telehealth's appropriateness in various situations that drove the previous restrictions.

For example, requiring clinicians and other providers to have a previous, in-person relationship with patients can inhibit needed access to care and is not consistent with most state-level or value-based payment policies. Similarly, blanket bans on audio-only can exacerbate disparities for patients lacking video technology or broadband access. Asynchronous modalities such as RPM may also be appropriate for services that do not require real-time interaction.

Strict limits on providing telehealth across state lines that were waived during the pandemic also do not appear warranted. States have a patchwork of requirements for obtaining and maintaining a medical license that burdens physician and other health professionals and make it difficult for clinicians to practice telehealth in multiple states—even when those states are contiguous or share a metropolitan area.

Waiver of these restrictions, allowed for additional surge capacity, dramatically lessened wait times for telehealth visits and helped triage many conditions that might otherwise have resulted in unnecessary in-person care that put patients at risk. Outside of a pandemic, care across state lines can ensure access to care in places with clinician shortages, allow residents who travel for work or seasonally to maintain consistent doctor-patient relationships and allow specialized care and expert consultations for those with serious conditions.

There are currently different definitions of telehealth, telemedicine and RPM. A widely agreed upon taxonomy of the various telehealth modalities can help clarify policy.

Finally, policymakers should not expect telehealth to resolve long-standing issues, such as care coordination and the move from FFS to value-based payment, but instead leverage telehealth-related policy development to help address these issues.



OVERARCHING ISSUE POLICY RECOMMENDATIONS

1. Policymakers should make permanent the following telehealth policy changes enacted during COVID-19 to improve access, patient safety and outcomes:
 - a. Removal of strict limits on sites where telehealth visits may originate, conditions clinicians may treat and which clinicians and providers may use telehealth.
 - b. Acknowledging that telehealth visits can establish clinician/patient relationships as long as they meet appropriate standards of care or unless careful analysis demonstrates that, in specific situations, ensuring patient safety, program integrity or appropriate high-quality care requires a previous in-person relationship.
 - c. Allowing audio-only telehealth where evidence demonstrates it to be effective, safe and appropriate, or where it is likely to be so and offers access to care that would otherwise be unavailable to a patient.
 - d. Allowing asynchronous telehealth (e.g., remote patient monitoring) when it is the preference or need of the patient on a limited basis as more clinical evidence is generated on best practices for ensuring quality, safety and program integrity.

AMERICAN TELEMEDICINE ASSOCIATION TELEHEALTH TAXONOMY

The most commonly used approaches in telehealth include:

- **Virtual Visits:** Live, synchronous, interactive encounters between a patient and a health care provider via video, telephone or live chat.
- **Chat-based Interactions:** Asynchronous online or mobile app communications to transmit a patient's personal health data, vital signs and other physiologic data or diagnostic images to a health care provider to review and deliver a consultation, diagnosis or treatment plan at a later time.
- **Remote Patient Monitoring:** The collection, transmission, evaluation and communication of individual health data from a patient to their health care provider from outside a hospital or clinical office (i.e., the patient's home) using personal health devices including wearable sensors, implanted health monitors, smartphones and mobile apps. Remote patient monitoring supports ongoing condition monitoring and chronic disease management and can be synchronous or asynchronous, depending upon the patient's needs. The application of emerging technologies, including artificial intelligence and machine learning, can enable better disease surveillance and early detection, allow for improved diagnosis and support personalized medicine.
- **Technology-Enabled Modalities:** Telehealth and virtual care solutions also provide for physician-to-physician consultation, patient education, data transmission, data interpretation, digital diagnostics (algorithm-enabled diagnostic support) and digital therapeutics (the use of personal health devices and sensors, either alone or in combination with conventional drug therapies, for disease prevention and management).



- e. Identifying and implementing policies related to use of these modalities that is based on the evidence of their effectiveness, safety and ability to meaningfully impact access to care.
 - f. Allowing insurers to provide telehealth technology, such as smartphones and tablets, as supplemental benefits.
 - g. Allowing telehealth across state lines by considering strategies to expedite licensure reciprocity between states, while maintaining important patient protections and disciplinary tools for bad actors.
2. Stakeholders, including policymakers, should agree on a taxonomy of telehealth care that fully describes the range of services and modalities—including types of audio-only encounters—that appropriately aligns standards, quality, payment (as appropriate) and program integrity. Within that taxonomy, policymakers should view “virtual visits” as another site of care rather than as a different type of care.
 3. Broadband and technology greatly facilitate telehealth and contribute to telehealth’s patient safety benefits, but they are not available to or affordable for all patients, particularly rural and underserved populations. Policymakers must promptly expand efforts to ensure universal access to broadband and other needed telehealth technology to bridge these gaps and avoid exacerbating disparities as health care moves into the digital age.
 - a. Policymakers should assess how to best address patients with specific telehealth challenges, such as those with translation needs or limited visual or auditory capacity, and who lack broadband access.
 - b. There also must be contingencies in place to address technology failures.

**REGINA BENJAMIN, MD,
FOUNDER, BAYOCLINIC/GULF
STATES HEALTH POLICY CENTER,
FORMER U.S. SURGEON GENERAL**



“Part of the infrastructure that needs to be put in place is the capability to work with ethnic communities and other demographic groups, on both sides of the Patient-Clinician relationship, to identify digital literacy and trust gaps that inhibit successful adoption of telehealth.”



4. Policymakers should develop and prioritize initiatives aimed at addressing the lack of trust and digital literacy gaps that inhibit successful telehealth adoption for patients, clinicians and other providers—with particular focus on populations that have struggled in the transition to telehealth during the pandemic. Policymakers need to identify groups at highest risk for low digital literacy and partner with patient and consumer groups to implement initiatives to increase digital literacy rates.
5. Policymakers should reinstate full enforcement of HIPAA patient privacy protections.

Conclusion

Telehealth has become an important part of the modern health care system. Lessons learned and data generated during the COVID-19 pandemic, as described in this report, can help policymakers maximize its benefits and address previous concerns about safety, program integrity, quality and costs. The broad consensus identified by the TTP on how to move forward should send a clear signal to policymakers that telehealth is a widely accepted, valued and expected care delivery option.

Consensus is emerging that telehealth is the natural evolution of health care into the digital age, not another type of care or new benefit. New technologies provide tools to address concerns about program integrity, care coordination and quality, and new data generated during the pandemic challenge previous assumptions about increased costs.

Policymakers will, of course, want to continue to assess the impact of telehealth as part of the new normal, but it is abundantly clear that telehealth should be here to stay.



The TTP thanks everyone who helped us gather data and shared thoughtful and well-informed comments to aid our work. The TTP convenors want to thank the members who took time from their busy schedules to help work through the deliberations needed to build our consensus. It is because of this incredibly generous insight and assistance that the TTP learned and accomplished so much in a short time.

Timeline of Temporary Telehealth Policy Changes



March 6: Coronavirus Preparedness and Response Supplemental Appropriations (CARES) Act

- First COVID-19 supplemental funding bill lets HHS temporarily waive Medicare telehealth restrictions.
- Adds “telehealth service” to what HHS can temporarily waive or modify.
- Applies to rural and originating site restrictions.
- Authority only exists during declared COVID-19 public health emergency.
- Limited to providers with a previous relationship with a patient: *
 - Furnished services to the patient in previous three years.
 - The provider is in same TIN as someone with an established relationship through Medicare.

March 10: CMS Medicare Advantage Guidance

- May waive/reduce cost-pays for COVID-19 tests, telehealth and other services if done for all enrollees.
- May provide Part B services via telehealth in any area and from many places, including homes.
- May waive prior authorization that otherwise applies to COVID-19 tests or services at any time.
- May provide smartphone/tablet as supplemental benefit.

March 17: CMS FFS Guidance

- Medicare covers office, hospital and other telehealth visits nationwide and in homes as of March 6.
- Telehealth waiver applies to all treatment during the Public Health Emergency, not just COVID-19.
- Providers already authorized in statute (1834(m)) get telemedicine pay, including NPs, MDs, PAs.



- Interactive audio-visual telecommunications system that permits real-time communication.
- Allows the use of telephones with audio and visual capabilities—smart phones permissible.
- HHS is waiving HIPAA enforcement for provision of services in good faith via FaceTime and Skype.
- CMS not enforcing statute’s Established Relationship language.
- The IG grants flexibility for providers to waive co-pays.
- Did not change e-visit codes.
- Controlled substance prescribing rules waived.

March 17: CMS Medicaid Guidance

- Flexibility to incent greater use of telehealth through 1135 waivers.
- Allows providers to use non-HIPAA compliant telehealth modes from platforms.
- Flexibility to make it easier for providers to care for people at home:
 - a. To allow telehealth and virtual/telephonic communications for covered State plan benefits.
 - b. Waiver of face-to-face encounters for FQHCs and Rural Health Clinics.
 - c. Reimbursement of virtual communication and e-consults for certain providers.
- Flexibility so Medicaid and Managed care enrollees could use telephones to receive care.
- Flexibility to let Medicaid pay for the same telehealth services Medicare now can.

March 17: Department of Health and Human Services, Office of Civil Rights

- Announces enforcement discretion to waive HIPAA penalties for good faith telehealth during COVID.
- Drug Enforcement Administration—Effective March 31.
- Allows controlled substance prescribing by telehealth if:
 - a. For legitimate medical purpose by practitioner acting in the usual course of professional practice.
 - b. Done via an audio-visual, real-time, two-way interactive communication system.
 - c. In accordance with applicable federal and state law.



March 27: Congressional Action: 3rd Package—Coronavirus Aid, Relief and Economic Security Act

- Amends Telehealth Network and Telehealth Resource Centers grant program to support evidence-based projects, extend grant period funding from 4 years to 5 years and ensures that 50% of funds go to rural projects (\$29M for each of FY21-25).
- Allows plans or employers to provide pre-deductible telehealth coverage for people with HSA-eligible HDPs, either discounted or fully covered. Amends Safe Harbor language and Disregard list.
- Eliminates requirement that clinicians must have treated patients in the past three years.
- Allows FQHCs and Rural Health Clinics to furnish telehealth in home or other setting, with composite reimbursement similar to comparable Medicare Physician Fee Schedule for telehealth.
- Eliminates the requirement that nephrologists conduct periodic home dialysis evaluations face-to-face.
- Allows hospice providers to use telehealth for face-to-face eligibility recertification encounter.
- Provides HHS flexibility to consider ways to encourage home health use of telecommunications and other communications or monitoring, consistent with the individual's care plan.

April 2: Federal Communications Commission

- Establishes the \$200M COVID-19 Telehealth Program to help providers connect to patients per the CARES Act.

Effective April 6: CMS Interim Final Rule

- Adds 80 services that can be furnished via telehealth.
- Adds payment codes for prolonged audio-only E&M services between the practitioner and patient:
 - a. Removes the preexisting relationship requirement on virtual check-ins.
 - b. Additional codes for licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists and speech language pathologists. Distant site restrictions remain for some.
 - c. Allows virtual required physician supervision via real-time audio/video technology.



April 10: Medicare Advantage Memo

- Allows risk adjustment for diagnoses via interactive audio-visual communication.
- Health risk assessment codes—96160 and 96161—are “add-on” codes.

April 30: CMS Second Interim Final Rule

- Along with 1135 waiver, removes remaining limitations on who can furnish telehealth, including physical therapists, occupational therapists and speech language pathologists.
- Along with an 1135 waiver, waives the video requirement for certain telephone E&M services, and adds them to the list of Medicare telehealth services.
- Allows hospitals to bill for services furnished remotely by hospital-based practitioners to registered outpatients, including at home, when it is a temporary, provider-based hospital department.
- Allows hospitals to bill the originating site (facility fees) for telehealth furnished by hospital-based practitioners to registered outpatients, including when the patient is at home.
- Expansion of codes approved for audio-only telehealth visits using the 1135 waiver: E&M, behavioral, SUD, educational services and annual wellness visits at same pay as an office visit.
- Medicare covers telehealth services provided by rural health clinics and FQHCs as per the CARES Act.
- New additions will be made on a sub-regulatory basis to speed the process.

State Actions

- Waived licensure laws to varying extents, to facilitate cross-border care (50).
- Pay at same rate as in-person care (32).
- Expand services (44), providers (32), phone (44), text/email (11), home as originating site (26).

Taskforce on Telehealth Policy (TTP)



Overarching and Subgroup Questions

To help guide the TTPs work, conveners crafted a set of questions, some overarching about telehealth and several specific to its three subgroups:

- Patient Safety and Program Integrity.
- Telehealth's Effect on Total Cost of Care.
- Data Flow, Care Coordination and Quality Measurement.

There naturally is overlap among these topics. Patient safety is essential for quality, as is cost, by avoiding costly patient harm. Program integrity to prevent and fight fraud, waste and abuse is integral to cost, quality and safety, because delivering unnecessary care diminishes quality and can harm patients. Data flow and care integration are necessary to optimize patient safety and prevent costly unnecessary care. Quality measurement to assess whether people get appropriate also affects cost, safety and integrity. The overlap quickly emerged in subgroup discussions and helped bring about consensus in the final recommendations.

OVERARCHING QUESTIONS

- What criteria should be for which emergency regulatory changes to keep vs. default to pre-COVID rules?
- What role can federal and state policy play in giving patients and providers tools and technical assistance to meet telehealth needs?
- What have we learned during the pandemic that can be applied to a policy on access, quality, safety, cost effectiveness and outcomes?



PATIENT SAFETY AND PROGRAM INTEGRITY

Patient safety concerns drove some pre-COVID telehealth restrictions.

- What do data tell us about program integrity with telehealth vs. in-person care?
- How can telehealth/virtual care technologies be used to enhance program integrity?
- How does your organization address program integrity with telehealth/virtual care and how does it differ from in-person care?
- What best practices should payers implement to optimize program integrity to prevent fraud and abuse?
- What do data tell us about patient safety with telehealth vs. in-person care?
- Are there opportunities for greater levels of patient safety in telehealth?
- What controls are needed to prevent diversion of controlled substances prescribed via telehealth?
- How can we best protect patient privacy while ensuring interoperable telehealth access that enables effective payer-provider collaboration?

DATA FLOW, CARE COORDINATION AND QUALITY MEASUREMENT

Telehealth was often seen as separate rather than part of core care.

- How do we fully leverage telehealth capabilities throughout the care and quality ecosystems?
- What are barriers to a more integrated quality measurement system, data sharing and patient-centered care for remote services?
- What are the best ways to assess the impact of telehealth expansion on quality and patient experience?
- How do we adapt the quality infrastructure to incorporate and support telehealth expansion and strengthen its infrastructure?
- What has your experience been with consumer telehealth satisfaction? Would they accept virtual care in an integrated care system?
- How might policies encourage patients and providers to view telehealth as another kind of care vs. a different care modality?

TELEHEALTH EFFECT ON TOTAL COST OF CARE

Before COVID, policymakers often assumed that expanding telehealth would increase costs.

- What have we learned about telehealth utilization during the pandemic?
- How should federal budgeting models adapt to reflect expanded telehealth access?
- What is needed to determine the effect of telehealth expansion on prevention, urgent care, post-acute care and so on?
- What principles should inform telehealth pay vs. in-person care and do these vary by service/mode of telehealth?



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Additional Notes

Additional Notes



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