COSMOS
Navigate the Compliance Universe

# Compliance Today - July 2021
# Telehealth: Pandemic-driven growth may lead to permanent change

By Stephen M. Angelette, Sara V. Iams, and Joelle M. Wilson

**Stephen M. Angelette** (sangelette@polsinelli.com) is Shareholder in the Dallas office, **Sara Iams** (siams@polsinelli.com) is Shareholder in the Washington, DC, office, and **Joelle M. Wilson** (jmwilson@polsinelli.com) is an Associate in the Chicago office of Polsinelli.

- linkedin.com/in/stephenangelette/
- linkedin.com/in/saraiams/
- linkedin.com/in/joelle-wilson/

The US medical community has witnessed increased demand for telehealth services both in rural and urban settings alike. Telehealth, as described by the *New England Journal of Medicine*, is often used as a blanket term that covers all components and activities within the healthcare system that are conducted through telecommunications technology, which includes telemedicine and other technologies like wearable devices and services like remote patient monitoring and virtual healthcare education, while telemedicine is often considered to be the use of technologies and telecommunication systems to administer healthcare to patients who are geographically separated from providers.[1]

The benefits of telehealth, namely increased patient access to care, have become increasingly present and overwhelmingly relevant in recent years, but a combination of inconsistent reimbursement and onerous state and federal regulatory requirements have stalled the penetration of telehealth among providers of healthcare services. Even so, the US has continued to see growth when it comes to the usage of telehealth, particularly in the past five years.[2]

Following years of inconsistent implementation, physician adoption of televisits/virtual visits doubled from 14% in 2016 to 28% in 2019, according to a study of 1,300 physicians conducted by the American Medical Association. Similarly, the Centers for Medicare & Medicaid Services (CMS) recently analyzed Medicare fee-for-service (FFS) claims data from March 17 through June 13, 2020[3] —although claims data are preliminary as providers have 12 months from the date of service to submit claims to CMS. The data show that more than nine million beneficiaries received telehealth services during that time frame. CMS reports that approximately 1.7 million beneficiaries received telehealth services in the last week of April 2020 alone. Claims data show that a significant number of beneficiaries are seeking services via telehealth, often at similar rates across demographics.

| Beneficiary use of telehealth by location | |
|---|---|
| Rural | 22% |

| Beneficiary use of telehealth by location | |
|---|---|
| Urban | 30% |
| **Beneficiary use of telehealth by sex and age** | |
| Female | 30% |
| Male | 25% |
| Below age 65 | 34% |
| Age 65–74 | 25% |
| Age 75–84 | 29% |
| Over age 85 | 28% |
| **Beneficiary use of telehealth by race/ethnicity** | |
| Asian | 25% |
| Black | 20% |
| White | 27% |
| Hispanic | 28% |
| Other | 26% |
| **Beneficiary use of telehealth by dually eligible (beneficiaries that qualify for both Medicare and Medicaid) vs Medicare-only beneficiaries** | |

| Beneficiary use of telehealth by location | |
|---|---|
| Dually eligible | 34% |
| Medicare-only | 26% |

**Table 1: Pandemic telehealth use statistics**[4]

In this article, we explore the historic factors limiting widespread adoption of telehealth and how the public health emergency (PHE) instituted as a result of the SARS-CoV-2 (COVID-19) pandemic has shifted the conversation and telehealth policy, perhaps permanently.

## Historical barriers to telehealth implementation

Reimbursement for telehealth has historically been the primary barrier to regular usage. For example, some insurers refused to reimburse telehealth services at the same or similar rates as in-person office visits, often citing the lack of cost for office infrastructure and overhead. Regulatory requirements have also been a significant hurdle for telehealth. For decades, state laws refused to allow a physician to provide professional medical services to a patient unless the physician was located in the same room as the patient. This was driven by a combination of insufficient technology and hesitation among state regulators, medical boards, and physicians alike that in-person care was clinically superior to distant care.

As patients and providers continued to seek improved telehealth benefits, and the medical and regulatory community began to acknowledge the clinical sufficiency of telehealth for certain types of services and, importantly, that expanding access to care decreases healthcare costs, insurers began to explore payment parity. Similarly, with the advancement of audiovisual technology, physicians and others began to see the benefits of telehealth, particularly among patients in rural areas with limited access to specialty care, and exerted pressure on payers as a result. States soon began to modify their laws to allow physicians to provide professional medical services to patients through audiovisual technology. Today, all US states and territories allow some form of telehealth by practitioners licensed in that state to be performed via telecommunication technology.[5] These changes opened the door to payment by commercial insurers and state Medicaid programs. Additionally, the advancement of telehealth has introduced programs such as the Interstate Medical Licensure Compact, which makes it easier for eligible and participating physicians to satisfy cross-state licensing requirements.[6]

Medicare coverage has served as another significant barrier to the provision of telehealth. Under federal law, Medicare coverage for telehealth is very limited, hampering practitioners' ability to offer it and Medicare beneficiaries' ability to access it. Specifically, Medicare beneficiaries must be located at an originating site, subject to strict geographic limitations; telehealth services are required to be provided via an interactive audio and video telecommunications system that permits real-time communication; and telehealth services may only be provided to established patients or those with an existing patient-physician relationship, among other requirements.[7] These requirements have limited the expansion of telehealth in the Medicare program because a significant percentage of beneficiaries are ineligible to receive the benefit.