CAHPR CENTER FOR ADVANCING HEALTH POLICY THROUGH RESEARCH

School of Public Health BROWN UNIVERSITY

Advancing Telehealth

Potential Policy Solutions to Ensure the Sustainable and Equitable Growth of Telehealth

Policy Brief

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Summary of the Issue

The COVID-19 pandemic catalyzed a dramatic shift in health care delivery, in which telemedicine became essential to patient care. During the peak of the pandemic, telemedicine visits accounted for 42% of Medicare outpatient visits in April-May 2020.[1]

However, many temporary telehealth policies that facilitated this surge are set to expire at the end of December 2024. The uncertainty surrounding the extension of these policies has caused substantial anxiety among patients who rely on telehealth and undermines any improvements in access it has provided.[2] Additionally, the current payment and regulatory frameworks for telehealth are not adequately aligned with its unique characteristics. Addressing these challenges will require comprehensive and permanent policy changes to ensure telehealth can continue offering high-quality, accessible, and cost-effective care.

This policy brief outlines key principles that could inform the next steps in telehealth policy. It reviews current research findings and concludes with several policy recommendations to address identified issues.

Overview of Policy Options

Expanding Access

- Permanently eliminate site-location requirements and allow for video visits for all conditions for Medicare beneficiaries
- Permanently allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) clinicians to provide telehealth as "distant" clinicians
- Consider a narrow exception to state licensure, allowing any physician to provide follow-up care with established patients via telehealth across state lines

Ensuring Equity

- Ensure that all patients are offered video visits and pay for audio-only telehealth visits for a limited period
- Remove in-person visit requirements before mental health visits

Adjusting Payment Structures

- Pay for telehealth visits at a lower rate than in-person visits
- Improve the value of remote patient monitoring through changes in payment structure
- Encourage innovation in payment models for telehealth using bundled payments or partial capitation

[1] Gray J, Tengu D, Mehrotra A. 3 surprising trends in seniors' telemedicine use during the pandemic. STAT. Published August 30, 2021. Accessed July 22, 2024. https://www.statnews.com/2021/08/30/three-surprising-trends-seniors-telemedicine-use-pandemic/

[2] Landi H. Health systems urge Congress to lay down a permanent road map for telehealth services as clock ticks on December deadline. *Fierce Healthcare*. https://www.fiercehealthcare.com/health-tech/deadline-looms-telehealth-services-health-systems-urge-congress-lay-down-permanent. Published April 11, 2024. Accessed July 22, 2024.

Key Principles for Telehealth Policy

Value over Cost Savings

Policymakers should prioritize value rather than cost savings when considering telehealth policies. Recent research suggests that telehealth, like most other healthcare innovations, increases overall spending.[3] Therefore, the focus should be on deploying telehealth in ways that improve care outcomes and access at a reasonable cost. By evaluating telehealth applications through a value framework, we can identify high-value uses that enhance patient care and access, such as reducing travel time and disruptions to daily life.

Avoid One-Size-Fits All Telehealth Policies

Avoiding one-size-fits-all telehealth policies is essential, as the benefits of telehealth varies across different clinical conditions, forms of telehealth, and types of providers. For example, telehealth can improve outcomes for some conditions that require immediate attention, like strokes, but offers limited benefits for common ailments like colds. Another critical distinction in telehealth policy is the type of clinician. Many clinicians have switched to a telehealth-only model, working independently or for a growing number of telehealth companies. For example, 13% of mental health specialists have closed their in-person clinic and only see patients via telehealth.[4] While telehealth-only providers may allow for better access to care, and introduce innovative models, their growing importance has raised new issues. Policies may need to be different for telehealth-only providers versus those who provide hybrid care.

Minimize Administrative Burdens

Reducing administrative burdens associated with telehealth is vital for improving efficiency and clinician satisfaction. The complexities of the current fee-for-service system payments for telehealth and state-specific licensure requirements are difficult to navigate and frustrating for both patients and clinicians.[5] Improved payment models and regulations will provide greater flexibility, making it easier for clinicians to deliver telehealth services and navigate licensure across states. This approach will help streamline telehealth delivery, reduce costs, and enhance the overall effectiveness of telehealth services.

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[3] Nakamoto CH, Cutler DM, Beaulieu ND, Uscher-Pines L, Mehrotra A. The Impact Of Telemedicine On Medicare Utilization, Spending, And Quality, 2019–22. *Health Affairs*. 2024;43(5). doi:https://doi.org/10.1377/hlthaff.2023.01142

[4] Hailu R, Huskamp HA, Busch AB, Uscher-Pines L, Raja P, Mehrotra A. Characteristics of Mental Health Specialists Who Shifted Their Practice Entirely to Telemedicine. *JAMA Health Forum*. 2024;5(1):e234982-e234982. doi:https://doi.org/10.1001/jamahealthforum.2023.4982

[5] Wilcock AD, Schwamm LH, Zubizarreta JR, et al. Legislation Increased Medicare Telestroke Billing, But Underbilling And Erroneous Billing Remain Common. *Health Affairs*. 2022;41(3):350–359. doi:https://doi.org/10.1377/hlthaff.2021.00791

Lessons from Recent Research

Telehealth expansions have improved quality and increased spending, but the changes are modest.

Concerns that telehealth could drive up healthcare costs have hindered its permanent expansion, with worries that its convenience might lead to increased care usage and additional strain on the healthcare system. Recent evidence from our research and other studies has started to shed light on telehealth's impact.[3] In this research, we exploited the variation in telehealth adoption across large health systems during the COVID-19 pandemic and compared changes from 2019 to 2021-2022. We estimate that greater telehealth adoption led to a 2.2% relative increase in total visits per patient per year, with 83% substituting for in-person visits. The increase was more pronounced among lower-income, non-white patients, and was accompanied by small improvements in chronic disease medication adherence and decreased emergency department visits, but with a $248 (1.6%) increase in per capita healthcare spending.

Our findings align with other studies, such as the Medicare Payment Advisory Commission analysis[6] and research in Ontario,[7] which also reported modest increases in visits and spending with varying impacts on quality. While our study indicated limited increases in outpatient visit utilization, it is crucial to recognize the limitations, including the influence of ongoing COVID-19 waves on healthcare-seeking behavior. Therefore,it is essential to continue monitoring telehealth's impact on quality and spending in different clinical areas.

Many patients face barriers to video visits.

Research indicates that both rural and underserved patients face barriers in accessing telehealth.[8] Patients with limited English proficiency, visual or hearing impairments, and those lacking necessary technology for video visits, such as lower-income individuals, racial minorities, Medicaid recipients, and people with disabilities, are disproportionately affected. Variability in telehealth use among clinics, including Federally Qualified Health Centers, underscores disparities influenced by IT infrastructure and investments in overcoming patient barriers to video visits. Given these barriers, many states have mandated coverage of audio-only visits to enhance accessibility. However, concerns persist regarding the quality of care provided through audio-only

[6] MedPAC. *Mandated Report: Telehealth in Medicare.*; 2023. https://www.medpac.gov/wp-content/uploads/2023/06/Jun23_Ch7_MedPAC_Report_To_Congress_SEC.pdf

[7] McAlister FA. Virtual care and emergency department use. *Canadian Medical Association Journal*. 2023;195(10):E376-E376. doi:https://doi.org/10.1503/cmaj.148052-l

[8] Marcondes FO, Normand SLT, Le Cook B, et al. Racial and Ethnic Differences in Telemedicine Use. *JAMA Health Forum*. 2024;5(3):e240131-e240131. doi:https://doi.org/10.1001/jamahealthforum.2024.0131

consultations, with some clinicians perceiving video visits as superior for treatment for some conditions such as substance use.[9]

Other forms of telehealth such as remote patient monitoring show promise.

Use of remote patient monitoring continues to grow in both Medicare and among the commercially insured. Remote patient monitoring shows promise in enhancing care for Americans with chronic illnesses, as evidenced by improved medication adherence, adjustments to treatment plans, and reduced hypertension-related hospitalizations[10] and emergency visits. Unlike other telehealth modalities, it is more likely to be utilized by racial and ethnic minorities and lower-income patients. However, similar to telehealth visits, remote patient monitoring increases healthcare spending. This is partly because it is often used by patients who are already managing their conditions effectively, leading to additional costs without necessarily reducing other types of care. Moreover, spending is also higher because use of remote patient monitoring is also accompanied by more visits.

Telehealth can be used to provide care across state lines.

The COVID-19 pandemic prompted temporary relaxations of licensure requirements across federal and state levels to facilitate out-of-state telehealth services, particularly benefiting Medicare beneficiaries and those with established relationships.[11] Early in the pandemic approximately 5% of telehealth visits among Medicare recipients involved out-of-state care, with higher rates observed in states near borders and rural areas like Montana and South Dakota. However, most of these regulatory flexibilities have ended and we have returned to pre-pandemic norms of licensure.

These geographic constraints have led to frustration among patients, who question why crossing state lines affects their access to care, often resorting to inconvenient measures like seeking WiFi in parking lots just across borders for telehealth visits.[12] Many patients also stopped following up with their out-of-state physicians.[13] Efforts such as the Interstate Medical Licensure Compact and

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[9] Uscher-Pines L, Riedel LE, Mehrotra A, Rose S, Busch AB, Huskamp HA. Many Clinicians Implement Digital Equity Strategies To Treat Opioid Use Disorder. *Health Affairs*. 2023;42(2):182-186. doi:https://doi.org/10.1377/hlthaff.2022.00803

[10] Tang M, Nakamoto CH, Stern AD, et al. Effects of Remote Patient Monitoring Use on Care Outcomes Among Medicare Patients With Hypertension : An Observational Study. *Ann Intern Med*. 2023;176(11):1465-1475. doi:10.7326/M23-1182

[11] Andino JJ, Zhu Z, Surapaneni M, Dunn RL, Ellimoottil C. Interstate Telehealth Use By Medicare Beneficiaries Before And After COVID-19 Licensure Waivers, 2017-20. *Health Aff (Millwood)*. 2022;41(6):838-845. doi:10.1377/hlthaff.2021.01825

[12] Shachar C, Richman BD, Mehrotra A. Providing Responsible Health Care for Out-of-State Patients. *JAMA*.2023;330(6):499–500. doi:10.1001/jama.2023.10411

[13] Bressman E, Werner RM, Cullen D, et al. Expiration of State Licensure Waivers and Out-of-State Telemedicine Relationships. *JAMA Netw Open*. 2023;6(11):e2343697. doi:10.1001/jamanetworkopen.2023.43697

special telehealth licenses have had limited effectiveness in mitigating these issues.[14] Instead, expanding exceptions to licensure requirements may be a more prudent solution. For example, some states like Arizona allow physicians to provide telehealth across state lines without a license for limited scenarios such as after-care from a procedure via telehealth. Similar exceptions for college students or those traveling for work or pleasure could allow patients to maintain continuity of care.

Potential Policy Options to Improve Telehealth

Expanding Payment and Access to Telehealth

Permanently eliminate site-location requirements and allow video visits for all conditions at any site to any Medicare beneficiary in the United States

Research[15,16] has highlighted that greater telehealth use can result in small improvements in access and quality and a broad expansion will also be simpler for clinicians to navigate. Perhaps most importantly, a large fraction of both patients and clinicians want telehealth to remain an option for certain medical services and policymakers will find it difficult to "take away" telehealth.[17] Finally, almost four years after the pandemic's start, it is reasonable to signal to clinicians that telehealth payments are here to stay so they can make investments in telehealth with more certainty.

Permanently allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) clinicians to provide telehealth visits beyond mental health visits as “distant” clinicians

Allow Federally Qualified Health Centers and Rural Health Clinics clinicians to provide telehealth visits beyond mental health visits as "distant" clinicians, enabling them to provide telemedicine care to patients in their homes. These clinics often treat patient populations with greater difficulties accessing care; therefore, their telehealth visits will likely be of higher value.

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[14] Center for Health Law and Policy Innovation, Harvard Law School. *Consensus Statement for Telehealth Licensure Reforms.*; 2023. https://chlpi.org/wp-content/uploads/2023/11/Consensus-statement-Circulation-AMH_FINAL.pdf

[15] Parimbelli E, Bottalico B, Losiouk E, et al. Trusting telemedicine: A discussion on risks, safety, legal implications and liability of involved stakeholders. *Int J Med Inform*. 2018;112:90-98. doi:10.1016/j.ijmedinf.2018.01.012

[16] Weinstein RS, Lopez AM, Joseph BA, et al. Telemedicine, telehealth, and mobile health applications that work: opportunities and barriers. *Am J Med*. 2014;127(3):183-187. doi:10.1016/j.amjmed.2013.09.032

[17] SteelFisher GK, McMurtry CL, Caporello H, et al. Video Telemedicine Experiences In COVID-19 Were Positive, But Physicians And Patients Prefer In-Person Care For The Future. *Health Affairs*. 2023;42(4):575-584. doi:https://doi.org/10.1377/hlthaff.2022.01027

Implement a narrow exception to state licensure allowing any physician to provide telehealth across state lines if they have an established prior relationship with that patient.

Federal efforts such as the Licensure Portability Grant Program to support state efforts to increase telehealth across state lines are a good first start. Future federal legislation should create a narrow exception to state licensure. In prior legislation, Congress has created exceptions for clinicians caring for athletes (Sports Medicine Licensure Clarity Act) and care within the Veterans Administration system (VA MISSION Act). Similar exceptions could be created for students who are away at college or for mental health treatment. There is wide support for the use of exceptions. These licensure exceptions could be limited to those with established relationships.

Ensuring Equity

Ensure that all patients are offered video visits and pay for audio-only visits for a limited time period, such as two to three years.

It is important all patients are offered video visits. While there is a recognition that telephone calls may be currently important for some rural and underserved populations,there are concerns about a future with a two-tiered system where the poor receive phone calls and the wealthy have video visits. Medicare should require clinicians providing an audio-only visit to attest that they offered the patient a video visit and that their clinic provides resources to patients who face barriers to video visits.

Remove the requirement for in-person visits before mental health visits.

In-person visit requirements limit the ability of telehealth to expand access to mental health services for patients who live far from any mental health clinician and, therefore, cannot have in-person care. This requirement is also inconsistent with current clinical norms.[18]

Adjust Payment Structures

Payment for telehealth visits should be less than in-person visits.

Since telehealth visits require less overhead than in-person visits, it is recommended that payments for telehealth visits be lower.[6] Physicians argue against this, claiming that their overall

[18] Mehrotra A, Busch AB, Uscher-Pines L, Raja P, Huskamp HA. In-Person Visits Before Initiation of Telemedicine for Mental Illness. *JAMA Health Forum.* 2024;5(4):e240234. doi:10.1001/jamahealthforum.2024.0234

practice expenses remain unchanged as they provide both types of visits and must maintain the same resources. However, cross-subsidizing in-person visits with telehealth payments could distort the market and give virtual-only companies an unfair competitive advantage, potentially pushing traditional practices out of business. Determining the correct difference in payment between telehealth and in-person visits is challenging. Currently, Medicare reimburses telehealth visits at roughly 25% less than in-person visits, which serves as a reasonable starting point.[6] This difference may need to be adjusted as more data on the actual practice expenses for telehealth visits becomes available. It is important to ensure that payment structures reflect the true costs to avoid market distortions and maintain a fair competitive landscape.

Improve the value of remote patient monitoring through payment reform.

While remote patient monitoring has shown great promise, there are several ways we can improve the value of remote patient monitoring. Instead of the current policy of unlimited reimbursement, Medicare should limit reimbursement of remote patient monitoring to 6 month episodes. Medicare should also limit reimbursement to focus care on patients with poor baseline adherence or use other techniques to incentivize its use among patients most likely to benefit. Finally, payment guidelines should be clarified so that clinicians understand that the remote patient monitoring payment encompasses time spent by clinicians adjusting medications. If remote patient monitoring is limited to fewer patients, reimbursement should be increased, given the substantial setup costs associated with such a program.

Give Medicare flexibility to create payment models that use partial capitation or bundled pay for telehealth applications such as portal messages.

Consider legislation giving Medicare as much flexibility as possible to create payment models that use partial capitation or bundled payments to pay for telehealth applications such as portal messages. Such alternative payment models could give clinicians the flexibility to use the full range of telemedicine tools (portal messages, video visits, eVisits, phone calls, eConsults, telemonitoring) best suited for an individual patient and clinical scenario and avoid the administrative burden of billing for each encounter.