Has telehealth's boom peaked? Lawmakers eye fixes, as providers wrestle with the unknown

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As many regions are reopening and returning to sense of normalcy, providers are forced to reckon with a regulatory issue that could have a significant impact on day-to-day operations: The telehealth freedoms empowered by emergency waivers may go away, or they could be curtailed, without legislative action.

As the COVID-19 public health emergency (PHE) endures, many states have begun opening up, and medical practices have started seeing patients and returning to doing procedures and operations (PBN 5/14/20). Faced with this near-normal environment, stakeholders are wondering whether the unprecedented expansion of telehealth by CMS and the private payers that follow them might be extended.

Congress has gotten busy on the subject, but the outcome remains to be seen. In recent weeks, Rep. Robin Kelly, D-Ill., has introduced an "Evaluating Disparities and Outcomes of Telehealth During the COVID-19 Emergency Act of 2020," which would analyze health care utilization patterns during the PHE. Rep. Troy Balderson, R-Ohio, introduced a bill calling on HHS and the Comptroller General of the U.S. "to conduct studies and report to Congress on actions taken to expand access to telehealth services" by various federal agencies.

Other legislators want to do more than study. The Senate's Committee on Health, Education, Labor and Pensions (HELP) conducted a full hearing on telehealth and COVID-19 on June 17, at which Sen. Lamar Alexander, R-Tenn., called for several of the current flexibilities in HHS telehealth policy to be made permanent. Alexander seeks to keep "policy changes that allowed physicians to be reimbursed for a telehealth appointment wherever the patient is located, including the patient's home, and É the policy change that nearly doubled the number of telehealth services that could be reimbursed by Medicare," according to the Committee's release.

The root of the matter

Politicians appear to be talking up telehealth because their constituents like it. At least various vendor and industry group polls suggest as much, including an "Americans for a Modern Economy" survey released June 2, which found that 70% of respondents "support permanent policy changes that would expand access to [telehealth] services." Independent research has been thin on the ground, but a June 9 Farleigh Dickinson University survey found 54% of respondents "are very to somewhat concerned that their own or a loved one's health is at risk due to delaying treatment for non-COVID-19-related medical problems" and, while only 24% of these respondents had tried telehealth, 72% of them said "their experience was the same or better than an in-person medical visit."

Also, there's big money behind telehealth, and the PHE has offered investors a huge opportunity, says Tom Davis, M.D., a health care consultant and author of Telehealth Confidential.

"The first week in March, the supermajority of health care delivery in the U.S. suddenly went online, massively accelerating the acceptance and adoption of the remote delivery of healthcare," Davis says. "These investors understand the 'first mover effect' — he who moves first gains the most — and they are looking to take advantage of it." These investors are likely to be loud voices in favor of keeping the PHE-influenced telehealth rules in effect.

Who could be against?

Why might there be a rollback? For one thing, the emergency waivers can't outlast the emergency. Once the PHE is declared over, so will be your ability to perform telehealth without meeting the restrictive "distant" and "originating" site requirements that kept utility suppressed.

As a June Center Insight Brief from analysts at KPMG puts it: "CMS has authority to make incremental telehealth requirement changes through further regulatory action É and is being encouraged to extend them; however, more significant, permanent changes to the conditions for telehealth reimbursement É will require Congressional action."

Even if the PHE remains in effect, private insurers are not bound by the HHS waivers; neither are they as vulnerable to public pressure as political actors and their own economic calculus favors a less generous telehealth reimbursement regime, says Heather R. Alleva, an associate with the law firm Buchanan Ingersoll & Rooney PC in Philadelphia. They have for the most part gone along with the feds' flexibilities, but they may backtrack.

Eric Anderson, M.D., chair of neurology at SOC Telemed, a telehealth company in St. Petersburg, Fla., notes that "many insurance companies had stated that they would stop their expanded telehealth offerings on June 1, [though] the majority

of them had extended that timeframe to late July through December. By setting these deadlines, most payers are insinuating that much of the current telehealth expansion is limited."

"Because of public demand, they won't push to go all the way back to [the original] limited telehealth reimbursement," Alleva says. But, perhaps with the justification that the efficacy and even the safety of the expanded services has not been proved, "insurers might want providers to go back to their previous policies, limiting coverage or parity of reimbursement to certain types of care where the misdiagnosis opportunity and consequences are not so great — i.e., where it is much easier to parallel the quality of care provided in-person for a particular service via telehealth."

A plea to keep it

The Centre for Neuro Skills, a provider of traumatic and acquired brain injury rehabilitation services, thinks it has a good argument for keeping more generous telehealth standards: They work, even in highly specialized and usually hands-on specialties, David Harrington, president and COO of the Centre, says.

The Centre, which helps brain injury patients recover motor skills through therapy, first experimented with telehealth before the pandemic on workers' compensation patients. "We focused on a supported-living model where, once patients were discharged, we could still remain in their lives and preserve the durability of outcome," Harrington says. "In the absence of such a role, a subset of patients may be at risk of decompensation."

When COVID-19 pushed them to an all-telehealth model, the Centre had to expand on that model and get tablets into the hands of all their patients Ð or in many cases their patients' caregivers, spouses or other patient advocates who helped the Centre's therapists perform distance therapy sessions.

"The staff had to get creative — how to do this at home?" Harrington says. Thus, a six-minute walk test normally conducted on a course at the Centre "became a walk around the back yard," and handweights normally used in strength training became a can of beans or a milk jug filled with water.

While most of Harrington's payers have gone along, now that lockdowns are easing and the Centre is seeing some patients on their grounds, many of them sought to further cut payments. "The problem on that is, it doesn't cost less to do telehealth," Harrington says. "We still have staff and bricks and mortar to pay for."

"If there's a resurgence of COVID-19, we may have to pivot back to full telehealth," Harrington adds. "If reimbursement drops, people won't get the access to care they need." The Centre has done its own study that shows the lifetime cost of care for their patients drops by millions of dollars when telehealth is used. "It's a better quality of life for patient too," Harrington says. "If the payer doesn't pay, a lot of these patients will go to Medicare [or] Medicaid, and there's a societal cost to that."

What about bandwidth?

An underexamined issue that might have a big effect on telehealth's continuing adoption is the patient's ability to get online. Bill Flatley, senior service delivery manager at enterprise solutions company OST in Grand Rapids, Mich., thinks this may also become an issue as the emergency fades away.

"Right now, internet providers such as Comcast are offering internet deals, making WiFi more accessible," Flatley says. "But these special deals are set to end at some point, and the increased connectivity will go away along with it."

Additionally, as part of its "Keep Americans Connected" program, the Federal Communications Commission (FCC) gave telecom providers such as AT&T and Sprint "additional spectrum," Flatley notes. That includes access to cellular frequencies which were not available to them in the past in order to service more customers in the pandemic. "It's unlikely the FCC will allow them to use this to continue unabated without some sort of change," Flatley says.

The proposed 2021 Medicare physician fee schedule, expected to contain telehealth changes, may provide a clue as to how CMS sees the shape of the future, Anderson says. Until then, prepare for the possibility that your telehealth freedoms may be restricted in the days to come.

Resources

- Senate HELP Committee, "Alexander: Make the Two Most Important COVID-19 Telehealth Policy Changes Permanent," June 17, 2020: www.help.senate.gov/chair/newsroom/press/alexander-make-the-two-most-important-covid-19-telehealth-policy-changes-permanent
- Americans for a Modern Economy poll results: https://floridapolitics.com/archives/338248-ame-survey-telemedicine-takes-off-in-coronavirus-era
- Farleigh Dickinson poll, "Majority of Americans fear for their health due to delaying routine care as a result of corona-19": https://view2.fdu.edu/publicmind/2019/200610/index.html
- KPMG, "Center Insight Brief: Medicare Teleheath and COVID-19," https://institutes.kpmg.us/content/dam/institutes/en/healthcare-life-sciences/pdfs/2020/medicare-telehealth-covid-19.pdf