Telehealth services have expanded to address COVID-19 emergency, giving consumers more options for care

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Over the past decade, telehealth services—including synchronous and asynchronous communications, as well as mobile health and remote patient monitoring—have been on the rise, in part due to the fact that more and more states are adopting telehealth-friendly policies. But by 2019, the proportion of U.S. consumers using telehealth services was still only about 10 percent.[1] In light of the COVID-19 emergency, national Medicare and Michigan Medicaid and commercial plans have responded with changes to coverage, opening up telehealth options to more consumers than ever before.

Telehealth (n)

The use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health, and health administration.

U.S. Department of Health and Human Services

Although telehealth has been seen as a particularly good way to fill health care gaps in rural communities and to address transportation barriers for older adults, in fact, telehealth has been more commonly adopted among younger adults and in suburban areas.[1] One reason for the slow uptake in key populations has been barriers to access. According to a 2018 report from the U.S. Centers for Medicare and Medicaid Services,[2] the two greatest barriers to telehealth among Medicare recipients were restrictions on allowing individuals to access telehealth from their homes and a ban on audio-only telehealth services. These policies put telehealth out of reach for many seniors.

Other challenges to the adoption of telehealth include restrictions on the services that can be rendered. Few telehealth options are covered for treatment and assessment of substance use disorders, for example. In addition, prior relationships have often been required in order to begin seeing providers via telehealth, and in-person, face-to-face appointments have been required for some services such as hospice and nursing home provider visits.

Finally, despite efforts from commercial insurers to provide coverage for telehealth options to incentivize their uptake, a 2019 report from independent law firm Foley and Lardner, LLP found that of 42 states with commercial payer telehealth statutes, only 10 states—less than one in four—had true parity when it came to payments.[3]

Telehealth mechanisms

Synchronous communication: Sometimes called telehealth visits, e-visits, or virtual visits, synchronous communication uses real-time audio and video between a patient and provider.

Asynchronous communication: Often called store and forward, asynchronous communication allows health data to be transmitted to a physician or specialist for review at a later time.

Remote patient monitoring: Allows physicians to track patient health care data, even after the patient has been released to home or another care facility.

Mobile health: Often used for consumer wellness tracking and monitoring through a mobile device.

[1] J.D. Power 2019 Telehealth Satisfaction Study https://www.jdpower.com/business/resource/us-telehealth-study
[2] CMS Information on Medicare Telehealth 2018 https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf
[3] Foley and Lardner 50- State Survey of Telehealth Commercial Payer Statuses 2019 https://www.foley.com/-/media/files/insights/health-care-law-today/19mc21487-50state-survey-of-telehealth-commercial.pdf

Telehealth Changes in Response to COVID-19

In the face of the COVID-19 pandemic, the challenge to expand telehealth options became urgent, as in-person office visits posed significant health and public safety risks.

Some changes to telehealth in response to the COVID-19 pandemic will have a long term impact, such as the expansion of telehealth capabilities among providers. With funding from the Federal Communications Commission (FCC) as part of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act)[4] providers can apply for funding to become better equipped to provide telehealth services, particularly in rural or medically underserved areas hit hardest by the pandemic.[5]

But most of the changes to telehealth were designed to be temporary, effective only during the COVID-19 emergency period, and it is yet to be determined when the emergency period will expire. Below are several key changes to federal, state, and commercial policies.

Federal Medicare telehealth service changes during COVID-19 emergency period:[6]

- Medicare enrollees can receive telehealth services from their home and regardless of whether they live in rural health professional shortage areas.
- Federally qualified health centers and rural health clinics can now bill Medicare for telehealth services.
- Audio-only telehealth service bans have been lifted for certain opioid use disorder treatments.
- Telehealth is expanded to include some hospice and home health services.
- Telehealth can be used as a replacement for face-to-face visits for some services including monthly visits for end stage renal disease and home dialysis patients and nursing home visits by a physician.
- Medicare enrollees no longer need to have a prior relationship with a provider to begin receiving telehealth services in certain instances.
- Health Insurance Portability and Accountability Act privacy rules have been relaxed to accommodate telehealth expansions to new communication platforms

The Digital Divide

Access to high speed internet technology is necessary, though not sufficient, for most telehealth participation.

21 million Americans lack access to high speed internet per the FCC.

Over 16 million of these are in rural areas--this represents about one-quarter of the rural population.

Many more Americans have *access* to high speed internet, meaning a high speed connection, but do not use it.

About **one in five adults making less than $30,000** a year do not use the internet.

About **one in four adults age 65 and over** do not use the internet.

Almost **one in three adults without a high school education** do not use the internet.

Reasons for not using the internet include a lack of computer literacy, cost, and privacy issues.

Pew Research Center

[4] S.3548 CARES Act https://www.congress.gov/bill/116th-congress/senate-bill/3548/text
[5] COVID-19 Telehealth Program https://docs.fcc.gov/public/attachments/FCC-20-44A1.pdf
[6] CMS Fact Sheet https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient

such as such as Google Hangouts video, Zoom, Skype, Facebook Messenger video chat, or Apple FaceTime.[7]

- In total, 80 additional services are now billable for telehealth with a certified clinician.

Michigan Medicaid telehealth service changes during COVID-19 emergency period:[8]

Most are effective until 30 days after the state emergency has ended or the first of the next month, whichever is later

- Michigan Medicaid enrollees can now receive telehealth services from their home, local health department, or other location deemed acceptable by the provider within telehealth security and privacy guidelines, rather than having to be physically present at a designated "originating site"[9] in order to receive care. [This policy will not expire after the emergency period.]
- Audio-only telehealth is permitted allowing patients to use an audio-only telephone for telehealth care.
- Face-to-face requirements are lifted for some services and telehealth is allowed as a replacement.
- Additional substance use disorder services are now eligible for telehealth services.
- HIPAA rules are relaxed to accommodate telehealth expansions to new communication platforms.[7]

Michigan commercial health plan telehealth service changes in response to COVID-19

Blue Cross Blue Shield of Michigan, Michigan's largest health insurer, has introduced a number of temporary telehealth policy changes in response to the COVID-19 pandemic. Notable examples include:

- No-cost sharing is required for in-network telehealth visits for common office visits and hospitalization follow-up visits for fully insured members.
- For BCBSM enrollees with a behavioral health benefit, no cost sharing is required for telehealth for common behavioral health visits for fully insured members.[10]
- Telehealth services are covered with all in-network providers for all Blue Cross PPO, Medicare Plus Blue PPO, BCN HMO, and BCN Advantage members.[11]

Other commercial plans throughout Michigan are also temporarily extending telehealth benefits and cost-sharing relief.

Telehealth beyond the COVID-19 emergency period

Some of the changes that have been made to telehealth policies during the COVID-19 pandemic may need additional guidance to adequately protect patient privacy in an increasingly digital world. For example, with expanded telehealth services there has been a relaxation of certain privacy and security rules, including HIPAA rules, to allow for telehealth video to be accessed over platforms that were not previously approved for delivery.

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[7] U.S. Department of Health and Human Services Notification of Enforcement Discretion for Telehealth https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

[8] Medicaid Policy Bulletins https://www.michigan.gov/mdhhs/0,5885,7-339-71551_2945_42542_42543_42546_42553-87513--,00.html

[9] The "originating site" is the physical location of the patient when using telecommunications to receive services from a physician or provider, who is at another location. The provider location is known as the "distant site."

[10] Blue Cross Blue Shield of Michigan provider alert April 3, 2020 https://www.bcbsm.com/content/dam/public/shared/documents/coronavirus/provider/alerts/updates-telehealth-procedure-codes.pdf

[11] Blue Cross Blue Shield of Michigan provider alert April 3, 2020 https://www.bcbsm.com/content/dam/public/shared/documents/coronavirus/provider/alerts/updates-telehealth-procedure-codes.pdf

Additional challenges may emerge as the adoption of telehealth expands. Telehealth may feel less personal than an in-person office visit and could impact the rapport between patients and providers, in turn impacting quality of care. Defining telehealth is another challenge as current terminology varies across federal, state, and commercial payers, and between provider organizations, causing confusion among consumers.

Despite these challenges, many telehealth-friendly policies will be worth keeping. The COVID-19 pandemic has forced policymakers to make changes to reduce the burden of seeking care during a social distancing period when an in-person visit presents a risk in and of itself. These policies have expanded the services available via telehealth and offered more flexibility for using telehealth in new situations. But after the COVID-19 emergency period has ended, many consumers may once again be burdened with long travel times or mobility issues that make it difficult to reach provider offices.

Additional changes to support telehealth may also be needed—beyond the changes implemented during the COVID-19 emergency period. Access to the technology necessary to participate in telehealth is needed on both the consumer and provider side and still lags behind for important constituents—including some who have been traditionally underserved. And true commercial insurer payment parity policies also lag behind in most states. Payment parity would put telehealth on par with in-person visits to encourage providers to pursue telehealth as an option whenever appropriate, giving more options to consumers.

Policymakers at every level will need to continue to address these issues to close the gaps in telehealth access.