

Telehealth Integration into Care Delivery

Post COVID-19






SEPTEMBER 2020




The COVID-19 pandemic has changed the way people interact with each other, turning to video and other forms of social media to stay connected. This embrace of virtual technology has extended to medical care and has paved the way for what may very well result in permanent changes in the how health care is utilized and reimbursed.

Recent policy changes during the COVID-19 pandemic have reduced barriers to telehealth, thereby promoting its use. Regulators and medical societies alike have endorsed the provision of telehealth services as a mechanism to facilitate public health mitigation strategies, providing a safe alternative to in person care (reducing potential infectious exposure). Telehealth is also helping to reduce strain on health care providers by minimizing the surge of patient demand during COVID-19 community outbreaks.

The **Centers for Medicare and Medicaid Services (CMS)** launched several emergency initiatives that expanded coverage, including:

-  Increasing the types of providers able to deliver telehealth services to patients
-  Allowing providers to use different modalities, including remote monitoring and phone-based services
-  Expanding the number of sites qualifying for coverage to include patient's home, federally qualified health centers and rural clinics

State regulators added their own emergency directives:

-  Expanding Medicaid coverage
-  Requiring private payors to pay for telehealth services
-  Allowing for coverage access across state lines



New Reimbursement Guidelines

Location: No geographic restrictions for patients or providers

Eligible providers: All health care providers who are eligible to bill Medicare can bill for telehealth services, including Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Eligible services: See this [list of telehealth services](#) from the Centers for Medicare & Medicaid Services

Cost-sharing: Providers can reduce or waive patient cost-sharing (copayments and deductibles) for telehealth visits

Licensing: Providers can furnish services outside their state of enrollment. For questions about new enrollment flexibilities, or to enroll for temporary billing privileges, use this list of [Medicare Administrative Contractors \(MACs\)](#) to call the hotline for your area.

Modality: Some telehealth services only require a telephone (see the Medicare Fee-for-Service section below for more details about audio-only services).

<https://www.telehealth.hhs.gov/providers/billing-and-reimbursement>

Even as we advance through the different twists and turns of the pandemic, telehealth has increasingly emerged as an alternative avenue for maintaining continuity of care – helping to avoid negative consequences for delayed preventive, chronic and/or emergent care.

While telehealth is not new, widespread adoption beyond simple telephone (provider to patient) connection has been relatively slow. Clearly, the COVID-19 pandemic is pushing against many of the barriers that had previously slowed health system investment in integrated virtual care delivery (funding, consumer adoption, provider alignment among them), and as a result, we believe there is opportunity now to reach beyond the immediate impacts of COVID-19, and look to telehealth (and virtual care delivery overall), as a useful format for “new normal” care delivery models.

Telehealth Modalities

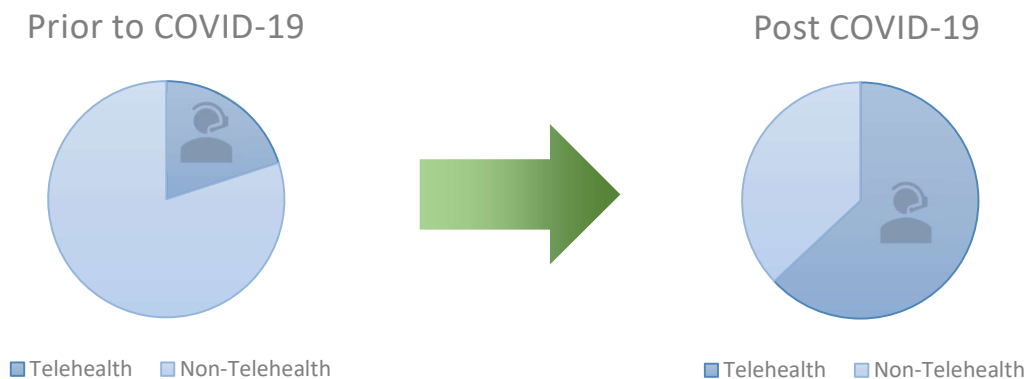
Synchronous: This includes real-time telephone or live audio-video interaction, typically with a patient using a smartphone, tablet or computer. In some cases, peripheral medical equipment such as a digital stethoscope might be used to conduct evaluation.

Asynchronous: This includes “store and forward” technology where messages, images, or data are collected at one point in time and interpreted or responded to later. Patient portals can facilitate this type of communication between provider and patient via secure messaging.

Remote patient monitoring (RPM): This allows direct transmission of a patient’s clinical measurements from a distance (may not be real time) to their health care provider.



In **May**, a survey of hospitals by Xtelligent Health Care put expected usage post pandemic at 63% versus just 20% prior to COVID-19.



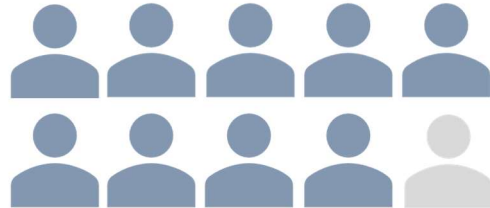
mHealth Intelligence News, “COVID-19 gives providers a blueprint for new telehealth strategies” May 18, 2020

An internal CMS analysis revealed prior to the COVID-19 pandemic (February 2020), Medicare beneficiaries accessed primary care services via telehealth at a rate of 2,000 visits/week. By **April** the number of telehealth visits increased significantly with nearly half of all primary care visits (1.28 million per week) delivered via telehealth – a 350-fold increase. Starting in May, that number decreased and has leveled off at about 700,000 visits per week.



ASPE Issue Brief, July 28, 2020 “Medicare Beneficiaries use of telehealth visits: Early data from the start of the COVID-19 Pandemic”

In **April**, a survey conducted by Sermo of 1,300 physicians found that 90% were using some form of telehealth, and 60% stated they planned to continue post the pandemic.



COVID-19 HCP Sentiment Surveys, Part 1, Physician engagement with Patients and remote/telehealth experiences”, April 2020 (Sermo)

The renewed opportunities presenting because of the COVID-19 pandemic opens the door to considering ways of integrating telehealth within existing clinical practices and protocols on an ongoing basis.

Various applications stemming from the current pandemic, as well as the opportunity to extend services beyond include:

- **Pre-screen patients** who may have symptoms and/or exposure to COVID-19, and referral as appropriate
- Provide **low risk urgent care** for non-COVID-19 conditions, identify and refer those who require additional face to face follow up
- **Care management** for chronic health conditions and medication management (including mental and behavioral health) – specifically for those who have difficulty accessing care (rural, elderly, limited mobility)
- Provide **coaching and support** for patients managing health risks, including things like weight management, nutritional counseling, and medication adherence
- **Monitor clinical signs** related to health risk and chronic conditions (e.g. blood pressure, blood glucose, other remote biometric assessment tools)
- Follow up **post hospitalization**
- **After hours care** and alternative urgent care consultation
- **Non emergent care** to residents in long care facilities.

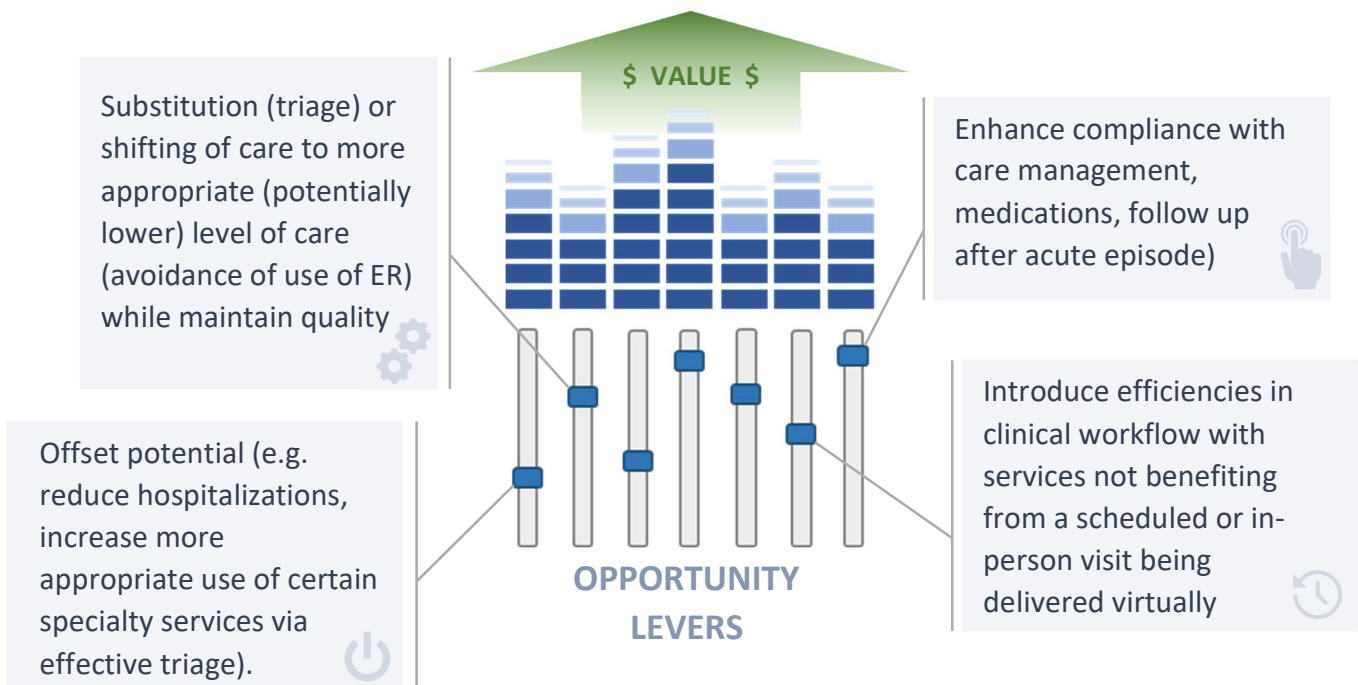
Data and analytics can help inform the best and most promising avenues for integration of telehealth (and virtual care) into existing clinical programs and workflows. Any related scaling decisions should be based on quantifiable opportunity assessment, including expected improvements in cost/quality of care, experience, efficacy, and financial impacts versus baseline.

Using current experience (health care utilization data) to answer immediate questions such as:

- Does care delivered virtually result in the same, better, or worse outcomes for patients?
- Does a telehealth visit for a condition results in the same action (follow up) as an in-person visit?
- Are patients overutilizing telehealth (requesting telehealth visits in greater frequency than in-person visits for same/similar condition)? Does this vary for specific conditions?
- Are telehealth visits being coded the same as in-person visits, for the same condition?

We work with our clients to construct analytic models supporting scenario planning, along several important dimensions relative to integration of telehealth into existing practices and programs.

The goal for analytic scenario modeling is to pinpoint opportunities to deliver greater value via integration into existing care delivery models. Potential levers (impact assessment) might include:



Suggested analysis parameters:

- **Population segmentation** (who might benefit and for what services, under what conditions)
- **Assignment of specific patient cohorts** to telehealth visits based on risk, co-morbidities, disease severity, age and other socio-economic factors. For example, lower risk patients incented to use telehealth for specific services, assignment of high-risk patients for more frequent virtual follow up)
- **Coverage and reimbursement modeling:** What groupings of services are amenable to delivery via telehealth and how might reimbursement policies be structured to produce the best outcome
- **Cost and utilization impacts** (overall and by target population, type and level of service)
- **Areas of opportunity** to increase patient (member) engagement and adherence to evidence-based care (improve quality).

In conclusion:

The COVID-19 pandemic has given telehealth a shot in the arm. This could become a new standard of care within a wide variety of service offerings, with the promise of creating new avenues for innovation and advancement in efficacy and quality of care. It presents opportunity to move from a highly scheduled (episodic) mode of care delivery to a more relational experience – including directly into patient’s homes – providing a continuous, data-rich platform that connects patient and provider anytime, anywhere.

However, in order to unlock this potential and harvest the best care delivery and business opportunities, a thorough and thoughtful review of impacts and potential outcomes should serve as the foundation for making the “business case” and helping to satisfying regulators in ways that will lead to continuation of some of the rule making enacted as part of the emergency measures, due to COVID-19.

Here’s what we should be watching out for as evidence for lasting changes in the enabling reimbursement and coverage landscape:



Which emergency measures will expire, and what actions will regulators take to advance and expand?



Will Centers for Medicare and Medicaid Services (CMS) continue to allow the patient’s home to serve as an approved telehealth site?



Will privacy and security guidelines (most notably HIPAA) be revised to allow providers and patients to connect across technology platforms (including audio only)?