American Academy of Actuaries

Issue Brief

Telehealth After COVID-19

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Key Points

- During the COVID-19 public health emergency, the need to limit in-person health care resulted in relaxing or waiving many of the legal and regulatory restrictions on telehealth, therefore increasing its use.
- As policymakers and regulators consider new or revised public policies regarding the availability of and payment for telehealth services now and in a post-pandemic health system, questions regarding the effects of telehealth on access to care, the costs of care, health outcomes, and potential fraud need to be considered.

Related Publication

- *Telehealth—A Digital Communication Approach to Improving Health*

The need to limit in-person care during the COVID-19 public health emergency led to temporary waivers or relaxations of legal and regulatory telehealth services restrictions. Telehealth utilization surged in the short term during the first few months of this period, then declined from its peak as in-person visits slowly returned. As policymakers and regulators consider new or revised public policies regarding the availability of and payment for telehealth services now and in a post-pandemic health system, questions regarding the effects of telehealth on access to care, the costs of care, health outcomes, and potential fraud need to be considered. Telehealth coverage and payment policies should optimally incentivize high-value telehealth services and deter low-value services.

In this issue brief, the American Academy of Actuaries Telehealth Work Group builds on its prior issue brief, *Telehealth—A Digital Communication Approach to Improving Health*, which discussed the benefits and implications of the digital communication revolution and how public policies could foster its contribution to improving health care. In particular, this brief identifies several considerations for telehealth coverage and payment policies.

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The appropriateness of telehealth varies by service type, patient characteristics, and patient needs. The work group's initial telehealth issue brief explored the types of services that lend themselves to telehealth. Promising results from various studies have been reported in the delivery of:

- behavioral health services,
- lower-acuity physical health services such as medication checks,
- follow-up visits and check-ins, and
- urgent care situations for lower-acuity issues such as rashes or flu-like symptoms.

When telehealth is an alternative to urgent care or an emergency room visit, the large cost difference between the modalities means even a modest reduction in utilization may yield material savings.

Different populations, such as those covered by the Medicare and Medicaid programs and commercial plans, typically have different needs and resources, so the appropriate use of telehealth services will vary. Many among low-income and underserved populations do not have smartphones or internet connectivity,[1] so providing Medicaid coverage for certain audio-only services such as mental health and substance abuse disorders can improve access. For Medicare beneficiaries, it is estimated nearly 40% of the elderly are "unready" for telehealth due to inexperience with technology, dementia, or difficulties with hearing, speech, or vision.[2] Some may benefit from assistance in setting up the necessary technology and some may get more effective care with home visits instead.

Payment policy that is in place for fee-for-service is adaptable for telehealth services. Provider payments are often based on fee-for-service (FFS) schedules that vary payment based on the time spent with the patient, the level of complexity of a visit, and whether a new or established patient. FFS payment schedules reflect the average resources consumed for the service/visit, the capital investment to support the visit, physical overhead costs, and the cost of administration. Telehealth visits can be structured in a similar fashion. Generally, telehealth visits are often less resource-intensive than in-person visits, which would lead to a lower cost per visit. However, lower reimbursement for telehealth visits could lead to lower adoption by providers.

1 "Digital divide persists even as lower-income Americans make gains in tech adoption"; Pew Research Center; May 7, 2019.
2 "Assessing Telemedicine Unreadiness Among Older Adults in the United States During the COVID-19 Pandemic"; *JAMA Internal Medicine*; Aug. 3, 2020.

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Providing that telehealth services providers and the information they garner are coordinated into the record of existing care programs is necessary for fully integrated care. Access to the electronic medical record (EMR) for information and documentation is an essential characteristic of effectively substituting remote care for an in-person visit. In general, the recognition of integrated care, as opposed to isolated visits, should be incented in both payment and regulation.

Alternative payment arrangements can facilitate better identification of appropriate telehealth use. Alternative payment arrangements provide incentives for high-quality and cost-efficient care and can lead to a greater emphasis on coordinated care. Allowing participating providers more latitude to implement broader telehealth services may identify optimal methods to incorporate telehealth into a modern delivery system.

Transition to a telehealth-enabled health system is reliant on support from all stakeholders. Telehealth is now an important part of the health delivery system and many initial barriers have been surmounted. However, without resources and continued support from financial, regulatory, and educational stakeholders, further progress will be impeded. Infrastructure to support the delivery will need to be a community endeavor to make sure there is sufficient access.

Regulatory incorporation of telehealth needs to focus on improving the overall health care system. Health care delivery regulations vary by state, type of market, and enforcement entities, and governmental programs—Medicaid (regulated federally and by the states) and Medicare (regulated federally)—often influence private medical insurance coverage. Assurances of access, quality and legal recourse can adapt to a system where some health care is delivered remotely. State licensing and oversight need to address situations where practitioners are not located in the same state as the patient.

A well-crafted regulatory and financial environment can appropriately foster innovation. As the health care delivery system—including telehealth—moves away from FFS reimbursement, regulatory flexibility in benefit design can assist with waivers and allow relaxation of network requirements to support the experimentation done under alternative payment arrangements. There is promise in lowering cost and increasing patient satisfaction through the use of smartphone applications and internet-connected digital devices to complete health screenings and monitor chronic conditions.

Providers will need to invest in new tools and enhance existing ones to supply services remotely. Provider approaches to financing changes to facilitate telehealth services will vary widely. In many cases government or payer funding will be necessary.[3] Telehealth, pharmaceutical, and physical health EMR integration will be essential to maintain continuity of care. Because the delivery system in the United States includes diverse payers with a variety of systems, there will need to be an effort to have consistency in the way information is shared.

Transitioning out of the COVID-19 public health emergency is an opportunity to establish the future direction of telehealth. Extending telehealth opportunities for providers who have supplied telehealth care and patients who have successfully accessed telehealth care during the public health emergency should be looked at in the context of whether it improves the health care system. What care, provided by whom, and to which patients telehealth is suited should be identified, as well as shortcomings inherent in the nature of telehealth and how to address them. Best practices should be well documented and potential for waste targeted.

On December 1, 2020, the Centers for Medicare and Medicaid Services (CMS) made some of the temporary public health emergency telehealth expansions permanent.[4] CMS added more than 140 services to the Medicare telehealth list and allows "beneficiaries in rural areas who are in a medical facility (like a nursing home) to continue to have access to telehealth services such as certain types of emergency department visits, therapy services, and critical care services." Additionally, CMS announced a commissioned study of its telehealth flexibilities during the public health emergency to see how telehealth "can be used to more efficiently bring care to patients and to enhance program integrity, whether they are being treated in the hospital or at home."

Also, funds were made available as part of federal emergency relief legislation enacted in 2020 for providers to start or expand their telehealth services during the COVID-19 emergency.[5] Extension of this program could encourage the transition to appropriate telehealth delivery after the public health emergency concludes.

3 "HHS Awards $20 Million to Combat COVID-19 Pandemic through Telehealth"; Department of Health and Human Services (HHS) press release; April 30, 2020. According to the HHS press release: "The funds will increase capability, capacity and access to telehealth and distant care services for providers, pregnant women, children, adolescents and families, and will assist telehealth providers with cross-state licensure to improve access to health care during the pandemic."
4 "Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients"; Centers for Medicare and Medicaid Services; Dec. 1, 2020.
5 HHS, Op. cit.

Conclusion

The innovations of the digitalization of information and the communications revolution will continue to change the way health care is delivered. While telehealth focuses on the patient visit, there are broader innovations of telehealth also being developed and deployed, such as electronic reporting of health status indicators, real-time continuous lab results, and therapies delivered in the home.

The patient-provider interaction through telehealth will be a fundamental part of that change. A challenge is to understand its possibilities and design a policy environment that encourages appropriate telehealth use so that it supports efficient delivery of quality care.

While telehealth services utilization has surged because of the COVID-19 pandemic—the newfound acceptance by patients and providers, the relaxation of restrictions, the preference of patients to limit interaction with others at medical facilities—telehealth's role in the future health care system is not clear.

Ongoing research, including actuarial research to understand who uses telehealth and for what reason, will be important. The basic questions of what services are best suited to telehealth, are there access or equity issues, and how payment methods interact with benefit designs will be important as telehealth's role in health care delivery is evaluated. The fundamental considerations of how telehealth affects patient outcomes and the total cost of quality care and what characteristics influence the extent and timing of those effects needs investigation. The results of such research should help monitor quality, predict utilization, and ultimately help quantify how the total cost of care will change.