Regulatory and market-driven factors affecting the implementation of telemedicine

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At the beginning of the year, some folks like to make predictions and then track prior predictions to assess their accuracy. Predictions in healthcare are generally straightforward, because change happens at a glacial pace, which makes being a futurist in healthcare an easy job. For instance, the *American Journal of Medicine* predicted the following in 2014: "Our estimate is that 25 percent to 50 percent of all transactions in the healthcare industry will be electronically outsourced by 2020. Twenty-five percent of all patient encounters with healthcare professionals could be by mobile health, using smartphones or smart wrist watches."[1]

Roll forward to today. The consumers are driving the movement with a saturation of personal data-gathering devices that can feed secure real-time or asynchronous platforms to the largest independent telemedicine providers. We are there, gathering data on wrists and in pockets, and the tailwinds are positive from an innovation perspective, but we still have a ways to go. There remain key legislative barriers.

Pockets of progress

I took note of three presentations during the 37th Annual J.P. Morgan Healthcare Conference in San Francisco, CA, on January 7, 2019.

Bernard J. Tyson, Chairman and CEO of Kaiser Foundation Health Plan, presented "Delivering Health in the 21st Century." Tyson stated that they had 77 million virtual encounters, comprising 59 percent of all encounters in a member base of 12.2 million, making Kaiser Permanente the nation's largest integrated health system.

Marc Harrison, MD and CEO of Intermountain Healthcare, the largest healthcare provider in the intermountain West, claims the lowest healthcare cost per capita (26% lower than the national average) and second highest rated system in terms of healthcare quality, based on Medicare readmission rates. It reports 13 telehealth sites offering 40+ services with 525,000 transactions in 2018.

Jason Gorevic, CEO of Teladoc, one of the largest telehealth providers, reports it has 23 million paid U.S. access members, 9.4 million fee-only live visits, and 2.55 million visits estimated in 2018 (9.4% utilization), up from 1.46 million in 2017. The growth is the real story here. Teladoc

promotes that they are the first virtual care entrant that handles system entry, care, and resolution in the areas of general medical (i.e., diagnosis and treatment), mental health, surgery support, and dermatology.

Telemedicine practice adoption

According to a press release by the American Medical Association (AMA),[2] reporting on a survey in the December 2018 issue of *Health Affairs,* about 15% of physicians worked in practices that used telemedicine to interact with patients, and 11% worked in practices that used it to interact with healthcare professionals. The survey data used for the study dates back to 2016 and lists adoption rates from highest to lowest for physician to patient:

- Radiologists – 39.5%

- Psychiatrists – 27.8%

- Cardiologists – 24.1%

- Gastroenterologists – 7.9%

- Allergists and immunologists – 6.1%

The survey data for adoption from highest to lowest for physician-to-physician or other healthcare professional was:

- Emergency medicine physicians – 38.8%

- Pathologists – 30.4%

- Radiologists – 25.5%

Videoconferencing was a more common telemedicine mode than remote patient monitoring or store-and-forward of patient data. Physicians in larger practices (50 or more) were 26.5% more likely to use it than those in smaller practices, suggesting that financial burden may continue to be a barrier to implementation, the authors said.

Carol K. Kane and co-author Kurt Gillis, a principal economist in the AMA's division of Economic and Health Policy Research, promoted the notion that the financial burden of implementing telemedicine is standing in the way of small practices. Based on the number of telemedicine technology platforms in the market today, many of which are very low cost, it can be safely assumed that may have been the case in 2016, but is certainly not the case today. Once again, we are dealing with lagging data, like the federal data. And as a result, it may be safe to say that adoption is significantly higher, as evidenced by the Kaiser numbers referenced above.

Clearly, telemedicine visits are on the rise, even though there is plenty of discussion and debate about efficacy, appropriateness, the immature and evolving regulatory frameworks, and nascent

technology platforms. More data will help bring clarity here. The key drivers pushing advancement include but are not limited to:

- Healthcare system adoption, such as Kaiser Permanente and Intermountain Healthcare;

- The Bipartisan Budget Act of 2018 that expanded Medicare coverage for telehealth for beneficiaries in accountable care organizations;

- The 2019 Physician Fee Schedule changes allowing for medical services delivered via asynchronous means[3] ;

- The Department of Veterans Affairs' (VA) aggressive embracing of telemedicine as a means to solve many of its woes;

- Parity law passage in the majority of states; and

- A reluctant but ever-growing willingness on the part of payers to embrace and reimburse for telemedicine—primarily driven by employer/employee (beneficiary) demands for opening healthcare to the on-demand economy—not because it lowers costs (it might), but because consumers are demanding the service.

Further, statements by the Centers for Medicare & Medicaid Services (CMS) are requesting that states support telehealth for Medicaid recipients. Speaking at the Alliance for Connected Care Telehealth Policy Forum for Health Systems in November 2018, CMS Administrator Seema Verma stated that Medicare's rules and governing statutes have clearly served as barriers to leveraging telemedicine. Verma stated:

> Under a proposed rule…in 2020, Medicare Advantage enrollees will have more options for receiving telehealth services beyond what is otherwise available in the traditional program…the proposed changes for Medicare Advantage are a major step towards expanding access to telehealth services because the rule would eliminate barriers for private Medicare Advantage plans to cover additional telehealth benefits for enrollees in MA plans. …Ultimately, whatever CMS is doing to promote telehealth, it's really all about one thing—to foster innovation and protect and strengthen the Medicare program in order to deliver on its promise to our elderly and disabled populations."[4]

About the same time, CMS released a report to Congress on telehealth utilizations. It is a lengthy document, but it can be summarized by the Executive Summary's conclusion that:

> [T]elehealth offers the promise of a technology and approach to care for a broad range of populations, including those enrolled in Medicare. Emerging evidence indicates that telehealth can be a tool for empowering healthcare providers and patients to offer the best approaches to care, including consideration of the patient's age, race/ethnicity, geographic location, and diagnoses, and provide high quality care without increasing costs.[5]

Where are we today?

Forty-nine states and the District of Columbia provide reimbursement for live video telehealth services through Medicaid fee-for-service programs. Massachusetts is the only state not yet participating.[6]

Several states, including Indiana, Michigan, and Missouri, have introduced or passed legislation that expands remote prescribing of controlled substances for treatment of substance use disorders.

Telehealth utilization through state Medicaid programs has expanded to allow recipients greater access, especially in schools. New York has expanded the list of state-sanctioned care delivery sites for telehealth to public, private, and charter elementary and secondary schools, and granted children virtual access to mental health counselors.

The VA is expanding its telehealth-focused programs and is now mandated by Congress to provide veterans with a self-scheduling, online appointment system, whether in person or via telehealth technologies. The VA's telehealth program now includes approximately 20,000 new patients and hosts more than 6,000 virtual visits each week.

The use of telehealth services under the Medicare Physician Fee Schedule was low in 2016 (and yes, we would love to see more timely numbers from CMS), but between 2014 and 2016, telehealth visits per beneficiary increased 79%. In 2016, some 108,000 beneficiaries accounted for more than 300,000 telehealth visits that totaled $27 million in spending.

According to a survey of commercial payers conducted as part of the Report to Congress: Medicare Payment Policy, March 2018,

> In general, cost reduction does not appear to be a significant consideration in plans' decisions to cover telehealth services. Plan representatives with whom we spoke cited competitive pressures from employers or other insurers rather than cost reduction as the primary rationale for covering telehealth services. Except for one insurer, which found that DTC services cost less than urgent care center and emergency department visits, insurers have not yet determined that telehealth reduces costs or improves outcomes. Cost-sharing levels ranged above and below levels of in-person cost sharing, suggesting the industry is divided about telehealth's potential value. Overall, the use of telehealth services under commercial plans has been low, at less than 1 percent of plan enrollees.[7]

Remaining barriers

The three primary barriers discussed in my prior articles published in *Compliance Today* magazine were coverage/reimbursement/parity, interstate licensure, and hospital credentialing. The three barriers are the same today; however, despite consistent headwinds presenting resistance in resolving issues around these three very key areas, progress is being made.

State legislation

The 2019 legislation outlook is not a busy one. If we look at pending legislation relevant to telemedicine, only a few state bills are pending that directly address telemedicine delivery:

- 11 states have yet to pass telehealth parity laws.

- 19 bills are pending that address multistate licensure, reciprocity, and multistate practice compacts beyond the already well-established nursing compact to physicians and other allied health providers.

- 9 bills are pending for demonstrations in various milieus, grants, and pilot projects.

- 3 bills allow for Medicaid reimbursement in Illinois, Mississippi, and Virginia.

- There are other pieces of legislation out that mention telemedicine, but those mentions are rationale for other funding bills, such as pushing out gigabit broadband to rural counties.

Federal legislation

The Bipartisan Budget Act of 2018, signed into law in February, expanded Medicare coverage for certain telehealth services to beneficiaries who are being treated by practitioners who participate in accountable care organizations (ACOs).

In June, the CMS characterized telemedicine as a cost-effective way of providing medical care and publicly encouraged states to use telemedicine and telepsychiatry to facilitate coordinated care for Medicaid recipients.[8] As of August 2018, 49 states and the District of Columbia provide reimbursement for live video telehealth services through Medicaid fee-for-service programs. Massachusetts is the only state not yet participating.[9]

In October President Trump signed into law the Special Registration for Telemedicine Act of 2018, requiring the Drug Enforcement Administration (DEA) to activate a special registration that allows physicians and nurse practitioners to prescribe controlled substances via telemedicine without an in-person exam. The DEA has no more than one year to complete the task.[10]

The most significant push is on the federal side and with the VA. The Care Veterans Deserve Act of 2019 (HR 23) jumps right over the hurdle of interstate licensure:

> Licensure of healthcare professionals providing treatment via telemedicine (a) IN GENERAL.— Notwithstanding any provision of law regarding the licensure of healthcare professionals, a covered healthcare professional may practice the healthcare profession of the healthcare professional at any location in any state, regardless of where such healthcare professional or the patient is located, if the healthcare professional is using telemedicine to provide treatment to an individual under this chapter. (b) LOCATION OF CARE.— Subsection (a) shall apply to a covered healthcare professional providing treatment to a patient regardless of whether such healthcare professional or patient is located in a facility owned by the Federal Government during such treatment. (c) RULE OF CONSTRUCTION.— Nothing in this section may be construed to remove, limit, or otherwise affect any obligation of a covered healthcare professional under the Controlled Substances Act (21 U.S.C. 801 et seq.).[11]

Bravo!

Investment tailwinds

Investment funding for digital health companies reached $9.5 billion in 2018, up more than 30% over the previous year, according to Texas-based Mercom Capital Group, a communications and research firm.[12] Of that funding, $7 billion went to US-based companies.

In the summary published by Mercom Capital Group, there were 698 deals that raised $9.5 billion for digital health companies in 2018, up from $7.2 billion in venture funding for 778 deals in 2017. Total corporate funding for digital health companies, including debt and public market financing, reached $13 billion in 2018, up 58% compared to $8.2 billion in 2017. A third of the venture capital funding was raised by just 18 companies, each bringing in over $100 million in 2018; the telehealth company American Well raised $291 million. In all, the portion of venture capital-funded digital health solutions in telemedicine came to $1.14 billion in 2018.

Caution areas, fraud, follow the money

Where there is money, there are criminals. Ripped from the headlines: "Four Men and Seven Companies Indicted for Billion-Dollar Telemedicine Fraud Conspiracy, Telemedicine Company and CEO Plead Guilty in Two Fraud Schemes."[13] The indictment, filed in October 2018, alleged that the charged individuals and companies conspired to deceive tens of thousands of patients and more than 100 doctors across the country for the purpose of defrauding private healthcare benefit programs out of $174,000,000 and that the defendants submitted $931,000,000 in fraudulent claims for payment.

HealthRight, a telehealth company, allegedly solicited insurance coverage information and prescriptions from consumers across the country for prescription pain creams and compounded products. The indictment states that doctors approved the prescriptions without knowing that the defendants were massively marking up the prices of the invalidly prescribed drugs, which the defendants then billed to private insurance carriers.

This is a reminder for all compliance and anti-fraud professionals that new innovation provides opportunity for the fraudsters to seek and find vulnerabilities in any system, including the telemedicine space. As the technologies evolve in telemedicine and the investment dollars follow, this is a stark reminder that building in solid, thoughtful controls is another key to success. Systems that build trust and cannot be compromised are far more likely to gain adoption and enjoy long-term success.

Overreaching in the midst of a crisis

The American Telemedicine Association (ATA) has been pushing the DEA to loosen prescribing rules in response to the signing of the Special Registration for Telemedicine Act of 2018. One has to ask if this is a good idea in the midst of an opioid crisis. ATA is seeking relaxed regulations that currently block mental health professionals from prescribing controlled substances via telemedicine. ATA sent a letter to the DEA pushing for changes to the Ryan Haight Act,[14] which bars providers from prescribing drugs without an in-person exam. Officials said changes are needed to allow prescribers to use telemedicine to open up access and help combat the opioid crisis. The ATA's recommendations[15] are to:

- Update the current DEA registration process to specify distinctions between traditional and telemedicine prescribing privileges;

- Allow both sites and prescribers to register for telemedicine;

- Allow for a public comment period within the one-year timeline for special registration activation;

- Ensure that telemedicine special registration is not restricted to any single discipline; and

- Allow telemedicine prescribers to apply for DEA registration numbers in multiple states at once.

Overcoming the myths

Without naming names, the argument that adoption is slow on the consumer side is not supported by the facts. None of the data even remotely suggest such a notion. The reluctance to providing the technology has come from the payers and some provider groups, borne out of fear that telemedicine would increase cost and diminish a provider's importance or relevance and also lower quality metrics. The other argument, citing slow adoption on the part of the healthcare providers, whether systems or payers, is that the technology is expensive and changing so fast that it is not yet practical to implement. This is but another fallacious statement. Most telemedicine applications are well-designed apps or cloud-based systems that function efficiently and at a very low cost.

Fear of innovation and new technologies should not be a barrier to achieving the goals of access,

high availability, ease-of-use, cost efficiency, and proven efficacy. Healthcare moving forward is going to be about platforms that promote access and shared data, not silos created by regulatory or corporate interests or poorly predicated supposition and myth.

Takeaways

- The top three practices using telemedicine for physician-to-patient visits are radiologists, psychiatrists, and cardiologists.

- The financial burden of technology used in implementation of telemedicine is becoming less of a barrier, allowing smaller practices the option of using telemedicine.

- CMS expanded telemedicine access to Medicare Advantage enrollees in order to serve vulnerable populations.

- Between 2014 and 2016, telehealth visits per beneficiary increased 79%.

- Consumer desire that fuels competition between the choices of health systems and practices is a factor driving technology and legislation.

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2 American Medical Association press release, "AMA offers first national estimate of telemedicine use by physicians" December 3, 2018. https://bit.ly/2SHpM0a
3 The Centers for Medicare & Medicaid Services (CMS) Physician Fee Schedule, CY 2019 Final rule, Telehealth, *"Remote Evaluation of Pre-Recorded Patient Information"* (HCPCS code G2010). https://go.cms.gov/2gPoyvr
4 Remarks by Administrator Seema Verma at the Alliance for Connected Care Telehealth Policy Forum for Health Systems. November 15, 2018. https://go.cms.gov/2Q7G7JC
5 CMS.gov: Information on Medicare Telehealth. November 15, 2018. https://go.cms.gov/2SVphPu
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8 Medicaid.gov, Telemedicine. https://bit.ly/2gT5nCG
9 Center for Connected Health Policy, "State Telehealth Laws and Reimbursement Policies Report" https://bit.ly/2BGRdMZ
10 115th Congress (2017-2018): H.R.5483 – Special Registration for Telemedicine Clarification Act of 2018, Chapter 4. Passed House amended June 12, 2018. https://bit.ly/2SXBEdT
11 116th Congress (2019-2020): Care Veterans Deserve Act of 2019 (H.R.23). https://bit.ly/2S6u4ct
12 Mercom Capital Group, "Q4 and Annual 2018 Digital Health (Healthcare IT) Funding and M&A Report. https://bit.ly/2Egy6LA

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14 N.M. Lacktman, T.B. Ferrante: "Congress Proposes Change to Ryan Haight Act to Allow Telemedicine Prescribing of Controlled Substances" *Health Care Law Today*, March 5, 2018. https://bit.ly/2oR6kfC

15 Letter regarding the American Telemedicine Association's recommendations re: the Ryan Haight Act Telemedicine Special Registration, January 10, 2019. https://bit.ly/2TRprV3