Telehealth Policy and Evidence: A Compendium of MED Reports From 2019–2021

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Contents

Introduction

The Medicaid Evidence-based Decisions Project (MED) is housed at the Center for Evidence-based Policy (Center) at Oregon Health & Science University in Portland, Oregon. MED produces reports and other tools to help state policymakers make the best, evidence-based decisions to support benefit design and coverage decisions made by state Medicaid programs. The links in this report lead to a clearinghouse of documents for participating MED members. If your state is a member of MED and you do not have access to this resource please contact med@ohsu.edu.

The MED collaborative has published a number of reports related to telehealth, including several completed prior to the rapid expansion of telehealth use prompted by the COVID-19 pandemic. This brief provides state Medicaid policymakers with a high-level synthesis of these report findings published on the MED Clearinghouse from 2018 through 2021, with links to the original reports. The reports we review here cover a range of telehealth modalities including live audio-video, audio-only, remote patient monitoring, and eConsult, and explore the impact of these modalities on different types of care, such as telebehavioral health and chronic care management. Staff from the Center analyzed these reports and captured cross-cutting themes and actionable takeaways.

Policy Authorities

Telehealth is optional for coverage by state Medicaid agencies, and programs have coverage flexibility as long as efficiency, economy, and quality of care requirements are met, allowing a great deal of coverage variation across state Medicaid programs (Home Tele.,[1] Fraud[2]).

- **Before and During the Pandemic**: Even before the pandemic, state governments including Medicaid programs were working to increase telehealth service availability and use in rural areas (Rural Tele.).[3] Following the COVID-19 federal public health emergency (PHE) declaration, the Centers for Medicare & Medicaid Services (CMS) issued guidance informing state Medicaid programs of existing authorities to cover many telehealth services and newly expanded PHE-related authorities enabled by Congressional legislation and CMS policy changes (Synchronous Tele.).[4] Most state Medicaid programs expanded telehealth coverage for nearly all services during the pandemic using their own state PHE declarations and leveraging these federal flexibilities. However, coverage criteria and associated requirements varied across state Medicaid programs and among different telehealth modalities (Synchronous Tele.,[4] RPM[5]).

- **After the Pandemic:** State Medicaid programs are currently gathering and reviewing telehealth data to inform future policy decisions, but generally have not made permanent decisions yet about which, if any, telehealth expansions will be permanent (Synchronous Tele.,[4] Rural Tele.,[3] COVID[6]). Shifts in federal and state laws and regulations, reviews of utilization and cost data, published studies, and feedback from stakeholders will inform these decisions (Synchronous Tele.).[4]

- **Federal Programs:** Following the PHE declaration, new federal programs were developed to increase telehealth access in various ways. Some focused on making telehealth start-up funds available, such as the COVID-19 Telehealth Program (Rural Tele.).[3] Other programs focused on reducing regulatory requirements for select providers such as Federally Qualified Health Centers (FQHCs) (Reimbursement,[7] Fraud[2]), and on facilitating coordination across federal agencies (Rural Tele.).[3]

State Considerations - Policy Authorities

- How will state Medicaid coverage for synchronous telehealth change going forward? Will it return to the policies in place prior to the PHE, retain the expanded coverage from the PHE period, or become a set of hybrid policies, blending aspects from both periods?
- How will the state Medicaid program leverage federal initiatives, resources, and flexibilities to increase access to telehealth services?

Clinical Evidence:

Health Outcomes

Various forms of telehealth result in similar or improved health outcomes, compared with in-person care, for numerous clinical conditions and specialties (eConsult,[8] Synchronous Tele.,[4] Telebehavioral,[9] COVID,[6] RPM,[5] SUD[10]).

- **Synchronous Tele.:** Compared to in-person care, synchronous telehealth (including live audio-video and audio-only telehealth) yields similar health outcomes and no greater occurrence of harms across a wide range of health conditions. This finding applies to the health conditions included in MED reports: asthma, cancer, chronic obstructive pulmonary disease (COPD), chronic wounds, genetic counseling, gynecology, heart failure, migraine, Parkinson disease, stroke, and postsurgical follow-up; it also applies to broad clinical areas such as primary care and behavioral health conditions (including Substance Use Disorder [SUD]) (Synchronous Tele.,[4] Telebehavioral,[9] COVID,[6] SUD[10]).
  - There is limited evidence comparing audio-video telehealth to audio-only telehealth. However, the few studies that do exist indicate that audio-only telehealth may be most appropriate for low-acuity conditions, follow-up services, and some behavioral health services (Synchronous Tele.).[4] People with opioid use disorder who received telephone support in addition to standard care with buprenorphine had better recovery outcomes compared with standard care alone (SUD).[10]

- **RPM:** Compared to usual care, people who receive remote patient monitoring (RPM) may experience significant improvements in multiple health outcomes, including reduced mortality for people with heart failure, reductions in blood pressure for people with hypertension, improved lung function for people with asthma, and improved HbA1c levels for people with gestational diabetes (RPM).[5]

- **eConsult**: When specialist follow-up was conducted using eConsults, access to care was improved, including a reduction in specialist response times, increased number of appointments, and faster time to appointments (eConsult).[8]

State Considerations - Comparative Health Outcomes

- How will state Medicaid programs include telehealth evaluation in telehealth service and coverage design?
- How can state Medicaid programs develop expansion policies based on the level of evidence for well-researched areas of care (e.g., chronic care management, behavioral health)?

Clinical Evidence:

Health Care Use

Overall health care use varied by condition and context of care (eConsult,[8] RPM,[5] Home Tele.,[1] Synchronous Tele.,[4] Telebehavioral,[9] SUD[10]).

- **Emergency Department Visits:** There was a reduction in emergency department (ED) visits for patients with cardiac complaints whose primary care provider used an eConsult system compared to those who did not (eConsult).[8] RPM and telehealth delivered in the home reduced ED visits for some conditions (e.g., COPD, heart failure, asthma) (RPM,[5] Home Tele.[1]). While ED visits did not change for people who had synchronous telehealth visits, there was some decrease in other unscheduled health care visits (Synchronous Tele.).[4] For example, some services provided via synchronous telehealth provide diagnostic services that may increase health care use, particularly ED visits.
- **Hospitalizations:** RPM use did not reduce hospitalizations for all conditions and patients, but did decrease hospitalizations for cardiac patients when RPM was added to an educational care component (RPM).[5] Among patients who received synchronous telehealth care, there was no increase or decrease in hospitalizations compared to those who did not (Synchronous Tele.).[4] However, there were fewer hospitalizations among some participants who received synchronous telehealth visits in the home (Home Tele.).[1]
- **Medication Use:** Patients with some conditions, such as gestational diabetes, and who received RPM reported increased medication use compared to those without RPM, but those with other conditions reported no differences (RPM).[5] Similarly, telebehavioral health for some conditions resulted in mixed findings related to medication use among patients with various behavioral health conditions (Telebehavioral).[9] In a study on the use of daily audio-video check-ins, a clear benefit was found in the improvement of medication adherence among young adults with opioid use disorder, leading to higher opioid abstinence (SUD).[10]
- **SUD Services:** Generally, patients receiving SUD treatment in person, via telehealth, or via both modalities experienced the same levels of health care utilization (SUD).[10]

State Considerations - Health Care Use

- How will current and emerging evidence about the outcomes of telehealth align with ongoing coverage of these services?
- Will RPM use be limited to patients with chronic illnesses and patients receiving home health services, or expanded for other circumstances such as after acute care?

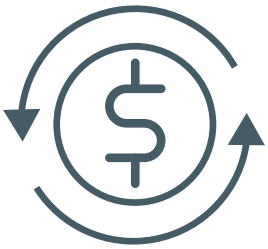
Stakeholder Engagement

Many state Medicaid programs conduct expansive outreach to understand the telehealth preferences of clinicians, but are less engaged with patients (Synchronous Tele.).[4]

- **Engagement Approaches**: Some states have created dedicated task forces to ensure a broad range of perspectives are included in deliberations about telehealth policymaking, including intrastate government staff, clinicians, patients, hospitals, and clinics (Synchronous Tele.).[4] Several states are also conducting patient and clinician surveys to better understand the preferences and needs of these stakeholders (Synchronous Tele.).[4] Some state Medicaid programs are working across their state governments to address non–health-related issues that can impact telehealth viability, such as broadband access (Synchronous Tele.,[4] Reimbursement[7]).
- **Managed Care Organizations:** Many state Medicaid agencies engage regularly with their managed care organizations (MCOs) to discuss telehealth issues of concern, through ongoing communication including data sharing (Fraud).[2]
- **Satisfaction:** Stakeholder outreach conducted by state Medicaid programs and independent surveys have shown that synchronous telehealth and eConsult can lead to high patient and clinician satisfaction across a range of clinical conditions (eConsult,[8] Telebehavioral Health,[9] Synchronous Tele.,[4] COVID[6]).

State Considerations - Stakeholder Engagement

- What will the state Medicaid program do to understand clinician and patient experiences and preferences regarding telehealth services, including those from rural, older, and lower-income populations, and across different racial and ethnic groups?
- How will the state Medicaid program work with other state agencies, local stakeholders, and others to improve needed infrastructure (e.g., broadband, wireless cellular service) to ensure high-quality telehealth interactions?



Reimbursement

Policy flexibilities and expansion of telehealth modality-specific billing codes have allowed a vast array service codes to be delivered using synchronous telehealth during the PHE (Synchronous Tele.,[4] Reimbursement[7]).

- **Codes and Modifiers:** State Medicaid programs use billing codes and modifiers to monitor utilization patterns, ensure integrity, and reimburse for all covered care, including services provided via telehealth (Reimbursement).[7]
  - Medicaid programs encourage or require clinicians to use billing modifiers to denote a given service has been provided remotely (Reimbursement).[7] Common telehealth-related billing modifiers include Place of Service (POS) 02, GT, GQ, CR, and 95.
  - Due to the lack of an audio-only Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) modifier, it has been difficult for payers to determine whether services have been delivered via audio-video or audio-only telehealth, hampering monitoring and evaluation efforts (Synchronous Tele.,[4] Reimbursement[7]).

TELEHEALTH-RELATED BILLING MODIFIERS

- GT: Synchronous telehealth (HCPCS)
- 95: Synchronous telehealth (CPT)
- GQ: Asynchronous telehealth (HCPCS)
- CR: Catastrophe related (HCPCS)
- POS 02: Telehealth place of service

- **Telehealth-Specific Codes:** CMS permits Medicaid payment for a range of telehealth modality-specific billing codes, including eConsult using bundled arrangements, RPM, and some audio-only services (e.g., psychotherapy) (Synchronous Tele.,[4] Reimbursement[7]).

- **Managed Care Organizations:** MCO arrangements often involve capitated payments, which allows MCOs to support telehealth adoption and cover more services than are explicitly reimbursed under a fee-for-service (FFS) model (Reimbursement).[7]

State Considerations - Reimbursement

- How can the Medicaid program make best use of telehealth billing codes and modifiers to support the monitoring and evaluation of services?
- Will the Medicaid program explore using value-based purchasing agreements and bundled service reimbursements tied to outcomes and quality of care improvements?

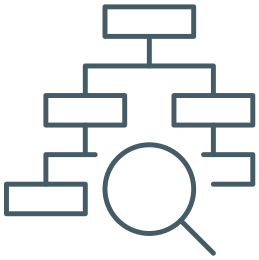
Costs

Telehealth generally results in lower costs for providing care compared with in-person care, though as discussed in the Health Care Use section, the evidence is mixed as to whether telehealth changes overall service usage (Synchronous Tele.,[4] Reimbursement,[7] Telebehavioral,[9] Rural Tele.[3]).

- **Cost Comparisons:** Synchronous telehealth, including audio-video and audio-only, may be less costly than in-person care in certain situations and for certain clinical conditions, largely due to the elimination of patient travel and use of emergency and nonemergency medical transportation (Synchronous Tele.,[4] Reimbursement[7]).
  - The equipment, technology, training, and staffing necessary to offer telehealth services can be prohibitive for providers, and reimbursement for technology or start-up costs is not available within all state Medicaid programs (Telebehavioral,[9] Rural Tele.[3]). However, there are numerous state and federal grant funding opportunities and alternative payment models (APMs) available (Telebehavioral,[9] Rural Tele.[3]).
- **Parity**: The majority of state Medicaid programs have reimbursement rate parity for services delivered in-person and using synchronous telehealth (Reimbursement).[7] This trend has likely been influenced by CMS rules permitting Medicaid coverage of telehealth without additional state plan amendments if payment parity is in place (Reimbursement).[7] Some state Medicaid programs have also supported payment parity as a means of expanding access to care (Reimbursement).[7]
- **Fees:** Rules vary across state Medicaid programs in regards to facility fees for originating site providers and encounter fees for care provided by FQHCs (Synchronous Tele.,[4] Reimbursement[7]).

State Considerations - Costs

- If total payment parity is not desired, for which modalities, services, and circumstances would the Medicaid program consider payment parity between telehealth and in-person services?
- How might the state Medicaid program leverage federal grant opportunities and APMs to fund costs related to building provider capacity to deliver care via telehealth?



Fraud

State Medicaid programs are actively monitoring and auditing telehealth service provision, generally to the same degree and using the same processes as for in-person care (Fraud).[2]

- **Documentation Requirements:** Some state Medicaid agencies have different documentation requirements for services delivered via telehealth versus in-person services (e.g., noting whether services were delivered via telehealth, start and stop times for visits) (Fraud).[2] The US Department of Health and Human Services Office of Inspector General (HHS OIG) recommends the use of billing modifiers to monitor, track, and audit telehealth services (Fraud).[2]
- **Review Standards:** The HHS OIG recommends that virtual care should have the same or a higher standard of review as other care modalities, as they have found telehealth services more vulnerable to fraud, waste, and abuse (Fraud).[2] Some state Medicaid agencies are actively monitoring the use of telehealth services through regular reviews of claims and encounter data to identify potential areas for concern (Fraud).[2] State Medicaid agencies we interviewed did not report hiring additional staff or contractors to monitor and track telehealth services (Fraud).[2]
- **Managed Care Organizations:** All MCOs have formal compliance programs and robust contract requirements around data collection, validation, and quality review to verify services, including telehealth services (Fraud).[2]

State Considerations - Fraud

- How can the state Medicaid program implement a data collection and analysis plan to track and monitor the delivery of telehealth services for particular conditions or clinician types?
- How will the state Medicaid program develop new quality metrics or adapt existing metrics for telehealth services, to ensure quality of services provided and to prevent duplication of services or other waste?

Security and Privacy

Payers generally place the responsibility on providers and patients for ensuring patient privacy and confidentiality related to telehealth visits (Home Tele.,[1] Synchronous Tele.[4]). Additional privacy concerns have surfaced as telehealth use has increased and the types of devices and sites used for telehealth services have expanded (Synchronous Tele.).[4]

- **Privacy Concerns:** Commonly stated concerns include thin walls in residences and health information communicated to patients who are in public settings (e.g., coffee shops) (Home Tele.).[1]
- **Specific Policies:** Telehealth policies for confidentiality and security were generally the same for audio-only and audio-video (Synchronous Tele.).[4]
- Just over half of states require informed consent specifically for telehealth services in statute, administrative code, or Medicaid policy (Home Tele.).[1]
- **Allowable Platforms:** Temporary pandemic-related flexibilities have allowed the use of telehealth platforms and devices that are not necessarily compliant with Health Insurance Portability and Accountability Act (HIPAA) requirements (COVID).[6]

State Considerations - Security And Privacy

- Which devices, modalities, or platforms will the Medicaid program allow for use in delivering synchronous telehealth services?
- How can Medicaid programs address patient safety and privacy for telehealth services delivered at home and in other nonclinical settings?

Conclusions

Medicaid telehealth policy continues to shift as the COVID-19 pandemic continues. Many state PHE declarations have ended and state governments are making decisions about the post-pandemic future of telehealth policies. The use of telehealth often requires patient access to reliable broadband internet and connected devices such as smart phones, as well as technological literacy.

State Medicaid staff identified connectivity as an important factor in the ability to expand telehealth services, particularly in rural communities, even before the pandemic. However, state Medicaid programs are limited in their ability to directly address these digital access issues, beyond allowing modalities such as audio-only telehealth, which are less dependent on newer technologies.

Additional clinical evidence and quality data regarding telehealth are being collected and analyzed across the country, informing these policies. MED continues to develop reports related to this topic, including *Audio-only Telehealth Services: Innovations and Operational Considerations and Audio-Only Telehealth Flexibilities for Group Psychotherapy Services: Evidence, Reimbursement and Coverage Criteria*.

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