Telehealth and the Covid-19 Public Health Emergency: Lessons Learned, Opportunities Realized, and a Glimpse at Things to Come

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The prevalence of telehealth as a mode of delivering health care was on the rise even before the COVID-19 crisis hit, but the onset of the pandemic effectively made it an indispensable component of the nation's health care delivery system. Many have lauded telehealth as one of the great successes of the current public health emergency declaration (PHE), as

it allowed practitioners across many disciplines to continue to treat patients without the increased infection risk of in-person contact and while preserving limited resources and personal protective equipment. During the pandemic, regulators at both the state and federal levels relaxed requirements and imposed payment parity obligations on insurers to help facilitate the expansion of this treatment modality. In this article we explore how the PHE impacted existing telehealth providers, how it provided an opportunity for the expansion of telehealth in new and different settings, and how notwithstanding the PHE related waivers and flexibility, regulators are monitoring and enforcing telehealth requirements.

The Evolution of Telehealth from the Perspective of an Established Digital Health Provider

While many have understandably focused on the ways that the COVID-19 pandemic impacted providers new to furnishing treatment via telehealth, a less explored but equally important area worth evaluating is how the pandemic impacted utilization trends among clinicians already experienced in using telehealth technology.

Here, we focus on how the pandemic impacted telehealth utilization at a national telehealth services provider, summarizing trends involving demand and utilization of behavioral health services, as well as whether such utilization differed along demographic lines. Then, we discuss whether the trends observed by this provider and elsewhere are likely to continue post-pandemic.

Increased Utilization in Behavioral Health

While the national telehealth provider saw its total visit volume increase across the board in 2020, significantly higher relative increases were seen in scheduled and unscheduled behavioral health and chronic illness visits, as compared to visits related to respiratory illness (*i.e.*, concerns surrounding COVID-19 itself). In particular, the demand for behavioral health visits grew considerably; such visits more than doubled normal levels during April 2020, for example.

While overall demand for virtual visits surged in early 2020, overall utilization levels were highest in the pandemic's early months before generally subsiding over the rest of the year. This was not the case in behavioral health, where tremendous demand and utilization continues among existing and new patients alike.

Industry authorities like the American Psychiatric Association have considered telehealth an important tool in behavioral health for years, citing nationwide shortages among behavioral health clinicians and noting telehealth's capacity to reduce

geographic barriers.[1] Those shortages have undoubtedly contributed to the continued increase in telebehavioral health utilization throughout the pandemic, but utilization also increased due to the stresses and difficulties of the pandemic itself.

Health Equity

Utilization of the telehealth provider's services increased significantly in the pandemic's early months, and the company's data suggests that lower-income communities were able to access telehealth services at the same rate as others. Specifically, the percentage of visits provided to lower-income individuals was generally stable from January and February 2020, where such visits accounted for 47% of visits, to April 2020, where the percentage grew slightly to 53%. [2]

The stability of the portion of telehealth visits accounting for lower-income patients as overall telehealth utilization soared in the early days of the pandemic is undoubtedly an encouraging sign. However, longstanding concerns about the "digital divide" in health care remain, largely involving questions around whether lower- income communities have the technology access and digital literacy required to utilize services via telehealth.

The seismic transformation that occurred in the telehealth industry during the COVID-19 pandemic was entirely unprecedented, and demand for virtual behavioral care continues to far outpace pre-pandemic levels. The forces that created the surge in demand will not subside if and/or when American communities reach levels of herd immunity or exit the PHE. The anxiety, isolation, and related issues that so significantly increased the demand for behavioral health treatment are more likely to evolve and present differently as the public health landscape evolves than they are to simply disappear. And the behavioral health provider shortage experienced in 2020 and 2021 was deepened, but not created, by the COVID-19 pandemic.

The industry has also experienced a sea change in public and industry perceptions of virtual care. Over the last year, consumer awareness of telehealth as an alternative to in-person care has skyrocketed and payers are more broadly incorporating digital health and telehealth into health plan benefit designs. Moreover, the emergence of state legislation mandating payment parity for telebehavioral health services will further support those trends. [3]

Taken together, these developments suggest that demand for virtual behavioral health services is unlikely to subside in the immediate future. Given telehealth's capacity to mitigate the impact of provider shortages and long wait times by increasing access to care, one can expect that telehealth will remain an important tool in the provision of behavioral health services.

Lawmakers and regulators will play an important role in determining whether lower-income communities can access health care treatment via digital health technology through efforts to expand broadband access in medically underserved communities, and in influencing public and private payers' policy decisions around whether video and audio services will continue to be covered without onerous restrictions, such as prior in-person visit requirements. In December 2020, for example, Medicare introduced a new requirement for Medicare Part B beneficiaries, mandating that patients must have seen their provider in the preceding six months for telebehavioral health services to be covered. [4]

In rural and underserved communities, the lack of affordable broadband and data is limiting access to many digital health and telehealth solutions. Expanded access to broadband connectivity remains a critical issue, as "broadband deserts,"—communities without access to high-speed broadband internet connections—remain prevalent in rural and lower-income communities in the United States.

Telehealth has tremendous potential to improve access to care within rural underserved communities, but realizing this potential will depend largely on choices made by lawmakers and insurers surrounding investments in broadband and restrictions on coverage (*e.g.*, decisions with respect to in-person requirements, modality restrictions, etc.). The speed and efficiency of those efforts will ultimately determine their success.

An additional challenge will be accelerating the adoption and use of digital health tools among underserved and disadvantaged communities. More than 77 million Americans are enrolled in Medicaid, representing a larger population than any other insurer in the United States, government-sponsored or private. And while smartphone adoption is quite high

within the Medicaid population, digital health adoption among Medicaid beneficiaries remains low, and digital solutions that are currently offered (by, for example, certain Medicaid Managed Care Organizations) are underutilized.

While obstacles remain, digital health solutions are uniquely equipped to improve health care among underserved and disadvantaged populations and are likely therefore to remain a priority. Geographic and transportation-related barriers to seeing a clinician in-person can be eliminated, and a simpler, more personalized health care experience can be created by finding the right health care professional for an individual patient. Digital health solutions also empower the patient to exercise greater control over the setting of care, location, and time of an appointment, as well as in their choice of provider. The tremendous upside of digital health solutions in combating health equity issues means that policymakers and the health care industry will presumably remain focused on accelerating the utilization of these tools in underserved and disadvantaged communities as we transition out of the COVID-19 pandemic.

The Expansion of Telehealth: A Nursing Home Case Study

Prior to the past administration's declaration of the COVID-19 PHE, the use of telehealth to provide care to skilled nursing residents was relatively novel: with limited availability for reimbursement outside the Medicare's skilled nursing facility (SNF) prospective payment system Patient-Driven Payment Model, [5] it was an additional expense that few long term care providers wanted to bear unless mandated by hospital partners or other payers with referral or network relationships. In addition, nursing staff were often reluctant to engage telehealth providers in on-line consults, viewing the visits as an additional burden in an already busy job. Yet, more and more referral sources were interested in their nursing home partners using telehealth consults as needed, in an effort to reduce readmission rates and improve the quality of care.

When congregate care settings proved to be particularly susceptible to spreading COVID-19, many nursing facilities found themselves in need of a means to limit the number of individuals entering their facilities. While we are all aware of the visitation restrictions many facilities adopted during the initial waves of infection, less publicized was the decision by many such facilities to relegate physicians to the outside, for fear of their becoming viral vectors. Thus, the use case for telehealth in the nursing home setting became even more imperative. Nursing staff also warmed to the change, finding they could get needed input in real time, at their patients' bedside. Such nurse-facilitated visits also helped to ease patients' discomfort with receiving virtual care.

With the PHE, the Centers for Medicare & Medicaid Services (CMS) expanded Medicare coverage to permit payment for virtual visits and check-ins as needed and regardless of the patient's location, and permitted providers to perform initial and discharge visits remotely. Further, the Office for Civil Rights (OCR) announced it would exercise enforcement discretion and not impose penalties for Health Insurance Portability and Accountability Act (HIPAA) violations arising out of the use of non-public facing communication technologies, paving the way for the use of telehealth via readily available apps like FaceTime and Skype, and without the need for costly bespoke platforms. While the latter is unlikely to survive the expiration of the PHE, those SNFs that have incorporated telehealth into their provision of care are unlikely to return to the pre-pandemic standard of waiting for open office hours, on-site physician rounding, or immediate referral to the emergency room to obtain needed physician input.

On the horizon for SNFs and other long term care providers may be the adoption and incorporation of remote physiologic monitoring technologies, such as weight, temperature, pulse, blood pressure, oxygen saturation, and heart rate, into their routine care plans. While the data obtained through such connected devices may seem overwhelming at first, once care team staff are trained—or alerted by outside providers—to recognize changes in monitoring data that might identify necessary changes in health condition, they may more timely provide the additional assessment or treatment that may result in better health outcomes—and improved facility retention rates—for their patients and residents.

In the 2021 final Physician Fee Schedule Rule, CMS signaled its willingness to continue paying for telehealth services—both to established patients in the long term care setting and for discharge planning—beyond the end of the PHE, and in some cases permanently. Thus, while the adoption of telehealth has required myriad changes to the provision of nursing home care—from the incorporation of "smart" telehealth carts to nursing care, to the adoption of new policies, procedures and

consents, as well as new goal setting and the retraining of staff and resident alike—the benefits of the use of telehealth in the skilled nursing setting may be changing the standard of care.

Telehealth Providers Beware

As a result of the COVID pandemic, certain requirements regarding the use and reimbursement of telehealth services were waived or relaxed at both the federal and state levels. However, the pandemic-related relaxation of certain telehealth requirements does not mean that all requirements were scaled back. Documentation is one such requirement that was neither waived nor relaxed. As the U.S. continues to make progress in moving past the COVID pandemic, regulatory agencies are starting to increase compliance enforcement efforts related to telehealth.

More specifically, documentation related to telehealth encounters—or lack thereof—has emerged recently as a point of focus for regulators in telehealth-related compliance reviews. Generally speaking, requiring practitioners to create and maintain documentation for the services they provide, including services delivered via various methods of telecommunication, has not lessened during the pandemic. Indeed, there often are additional record keeping burdens that come along with providing services through telehealth because there are both federal and state laws mandating that a patient's consent to receiving treatment via telehealth be clearly documented.

Notably, even before the pandemic, oversight activity conducted by the Department of Health and Human Services Office of Inspector General (OIG) that focused on telehealth services reimbursed under the federal Medicare program found that provider documentation fell short of demonstrating that the reviewed services were delivered and billed in accordance with applicable Medicare rules. Specifically, the OIG reviewed documentation related to a sample of 100 claims for telehealth services billed to Medicare in 2015 and, according to a report issued in 2018, the agency found that roughly one-third of the claims included in the audit did not satisfy Medicare coverage and/or payment requirements. At that time, OIG recommended CMS continue to closely monitor telehealth billing and offer training to practitioners on Medicare telehealth requirements.[6]

Notwithstanding OIG's prior findings of compliance vulnerability in this area and the maintenance of documentation requirements even during the pandemic, there are signals within the health care industry that some practitioners may nevertheless have relaxed their record keeping practices even as their delivery of services through telehealth increased. We have become aware that the Medicare Unified Program Integrity Contractor (UPIC) has been contacting practitioners to request documentation supporting services or items that were ordered after a telehealth encounter between a practitioner and patient. The UPIC has shown particular interest in practitioners who ordered durable medical equipment (DME) items for patients after telehealth encounters, even though the practitioners who ordered the items or services were not the ones who billed for it. That is, even though the DME suppliers bill for the items provided to patients, the UPIC is focusing on the practitioners who order the items to determine if sufficient justification exists to support their provision to patients. Under Medicare rules, in order to qualify for Medicare coverage, DME items must be dispensed pursuant to a valid physician order. In this regard, DME suppliers that dispense DME items directly to Medicare beneficiaries need to first obtain a physician order to be able to submit a claim for reimbursement for the item. Agencies charged with enforcing Medicare regulatory requirements have previously identified schemes pursuant to which individual practitioners like physicians or physician assistants generated a large volume of orders for DME items dispensed and billed by particular suppliers allegedly in exchange for kickbacks. Consequently, when auditing DME claims, CMS and its contractors often will look closely at practitioners' orders that support the claims that are being billed by the suppliers. This appears to be what the UPIC is doing now.

Medicare regulators have shown particular concern about DME items dispensed pursuant to practitioner orders resulting from telehealth encounters because this technology allows individual practitioners to have encounters with patients who are in a physically distant location and they may have never actually examined any patient in person. In this regard, where the practitioners who ordered the DME have not been able to provide the UPIC with adequate documentation related to the telehealth encounters in question, the Medicare program has revoked practitioner billing privileges on the grounds the

provider failed to meet the general condition of Medicare participation that practitioners "maintain documentation" of services they deliver or order.[7]

In reviewing these types of claims, Medicare contractors have clearly communicated that the individual practitioner must have ready access to records relating to the particular services that practitioner provided even if the practitioner furnished the services in question through a telehealth company (such as TeleDoc) that transmits and maintains records on their online platform. In other words, a practitioner cannot rely solely on the records transmitted through the particular telehealth platform to satisfy compliance requirements, but must have his or her own copies (electronic or paper) of relevant medical records. The Medicare program will not accept, "go ask the telehealth company for them" from a practitioner in a response to a specific document request related to telehealth encounters involving that practitioner.

While, as alluded to above, the UPIC's recent inquiries to providers about their documentation of telehealth services in this area appear to have been prompted by alleged fraud schemes involving a particular telehealth company and a number of DME suppliers,[8] they nevertheless potentially portend of future audit and enforcement activity by regulatory agencies (and even possibly third-party commercial payers) directed toward practitioners. In fact, to date, the OIG has announced plans for seven different audit initiatives that will focus on services delivered via telehealth modalities. For example, the OIG has commenced what it describes as a "two phase" audit of "Medicare Part B telehealth services" and is anticipating releasing a report sometime in 2021. Phase 1 of this Part B services audit will review whether telehealth encounters for evaluation and management services, opioid use disorder, and psychotherapy met Medicare requirements, while Phase 2 will focus on whether a larger scope of Part B services satisfied rules relating to distant and originating sites and other telehealth coverage requirements.[9] Other OIG audit initiatives related to telehealth are going to be specific to particular categories of providers, like home health agencies and will look at telehealth services reimbursed under certain state Medicaid programs.

With federal enforcement agencies already clearly making a priority of reviewing the appropriateness of payments made for telehealth services under federal health care programs during the pandemic, and considering that commercial health plans also have furnished reimbursement to practitioners for an unprecedented volume of telehealth during the PHE, it stands to reason non-government payers soon will follow the lead of the OIG and Medicare UPICs and engage in post-payment reviews designed to ensure that these reimbursements were properly made. Review of the documentation practitioners have maintained related to the services provided will be an important component of the ongoing and anticipated future audit activity surrounding telehealth services

Consistent with the foregoing, for practitioners that significantly increased the volume of services they delivered via telehealth during the pandemic, the time has likely come to engage in self-auditing to ensure that they satisfied documentation requirements for all services furnished via telecommunications methods, if they have not already. In particular, practitioners who furnished services to patients through referrals from, or arrangements with, telehealth companies, will want to ensure that they have their own copies of records related to telehealth encounters, even if there is documentation maintained on the telehealth companies' electronic platforms. It has long been an adage in the health care industry that "if it wasn't documented, it wasn't done" and it does appears that this rule-of-thumb applies equally to telehealth services.

[1] *See, e.g.,* American Psychiatric Association Position Statement on Telemedicine in Psychiatry (May 2018).

[2] Lori Uscher-Pines *et al*, "Where Virtual Care Was Already a Reality: Experiences of a Nationwide Telehealth Service Provide During the COVID-19 Pandemic," Journal of Medical Internet Research Vol. 22 No. 12 (2020).

[3] *See, e.g.,* Mass. SB 2984 (Jan. 1, 2021).

[4] *See* Consolidated Appropriations Act of 2020, § 123.

[5] CMS pays SNFs for care based on ICD-10 codes that classify patients into case-mix groups focused on patient characteristics, rather than the amount or type of care provided.

[6] Department of Health and Human Services Office of Inspector General, "CMS Paid Practitioners for Telehealth Services that Did Not Meet Medicare Requirements," Audit A-05-16-00058 (Apr. 5, 2018), https://oig.hhs.gov/oas/reports/region5/51600058.asp.

[7] 42 C.F.R. 424.516(f).

[8] *See United States of America v. Belter*, *Laughlin and Luke* , Criminal Complaint, filed in the United States District Court, District of New Jersey (Sept. 8, 2020).

[9] OIG, "Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency," https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000556.asp.

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