

The Center for Telehealth & eHealth Law's (CTeL) Briefing Memo for:
The Ways and Means Subcommittee on Health's Hearing on
Charting the Path Forward for Telehealth
Wednesday, April 28, 2021

Who is CTeL?

For 25 years, the Center for Telehealth & e-Health Law (CTeL) has been the leading source of legal, regulatory, and policy intelligence for the telehealth community. As a 501(c)(3) nonprofit, political and vendor-agnostic research institute, CTeL's research, Summits, and coalitions have forged the path for modern-day virtual care delivery. CTeL is committed to continuing its legacy of leadership as we work to make high-quality, accessible virtual care a reality for all through our data- and research-backed policy initiatives.

What is Telehealth?

The US Department of Health & Human Services (HHS) defines "telehealth" as the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Telehealth technologies include:

- **Videoconferencing:** audio-visual consult between patient and health professional in real time;
- **Store-and-forward:** asynchronous transmission of a health record, document, or image;
- **Remote patient monitoring:** connected electronic tools that capture personal health and medical data for transmission (either in real time or asynchronous) to a health care professional;
- **Mobile health (mHealth):** health information delivered through mobile devices.

The Call for CTeL Research

In 2015, CTeL was asked by congressional staff to provide telehealth cost impact research to the Congressional Budget Office (CBO) in order to enable more accurate scoring of telehealth legislation. The research needed to meet academic standards and be funded by a neutral source. This data was necessary to reevaluate telehealth governmental costs, which was scored by CBO in 2001 using likely inaccurate data. CBO's cost-estimate inflated telehealth's cost to Medicare by as much as 83%. This resulted in the passage of Medicare telehealth reimbursement restrictions designed to suppress utilization and keep costs low. These restrictions included:

1. **Geographic Restriction/Zip Code Requirement.** The practitioner can only be reimbursed if the patient is in a geographic region/zip code that is deemed rural by the Centers for Medicare & Medicaid Services (CMS).
2. **Location of the Patient Restriction.** The patient must be located at specific "originating" sites deemed appropriate by CMS, which exclude a patient's home or workplace.
3. **Practitioner Restriction.** The patient must be seen by a practitioner deemed appropriate by CMS.

4. **CPT Code Restriction.** Practitioners can only be reimbursed for specific CPT codes outlined in the Medicare Physician Fee Schedule.

These restrictions are a major access to care barriers. To address CBO's initial concerns, CTeL began groundbreaking research surrounding cost data to support removing these barriers. CTeL and its research partners have completed Phase I and II of this research process and are in the process of finalizing Phase III. Those phases are outlined below:

Research Timeline: Assessing the Value of Telehealth – Cost, Quality, Fraud and Abuse

Phase I: Literature Review. Following an exhaustive review process, a team of researchers from Mercer University in Georgia reviewed 16,900 telehealth studies from 2007-2017, finding that only a small fraction of published literature provided sufficient information to assess the costs associated with telehealth versus in-person treatment.

Findings: Mercer University found cost savings for patients, providers, and payers. However, given the variability in how the data was collected and reported, the authors concluded that there was insufficient data to perform a meaningful analysis of costs. This laid the foundation for Phase II and III of the research.

Phase II: Data Dictionary. The Phase I Literature Review identified the need to harmonize telehealth data to perform meaningful and reliable analyses across health systems, practitioners, and payment sources. Using data from large health systems, independent data scientists, Jason Goldwater, PhD and Yael Harris, PhD, identified common elements that could be standardized. The data dictionary provides a roadmap to normalize telehealth data to effectively analyze its impact on access, utilization, costs, and quality.

Findings: The data collected for the first iteration of the data dictionary revealed that the single most prevalent telehealth service is for behavioral health for the initial patient encounter, particularly in the treatment of severe mental illness including personality disorder, bipolar disorder, and unspecified psychosis.

Phase III: Cost Impact Studies. Employing the data standards outlined in the data dictionary, 5-10 large health systems are currently effectuating data sharing with researchers for all telehealth encounters during the pandemic. This will allow independent researchers to conduct statistically significant analyses to gain a better understanding of telehealth utilization, services provided, payers, patient characteristics, and costs of care. Using this information, we will conduct a series of analyses in Summer 2021 to assess the cost and value of telehealth.

Fraud and Abuse

Certain stakeholders have raised concerns about whether expanded telehealth access may increase the prevalence of fraud, waste, and abuse in the Medicare system. However, these concerns are largely in response to the 2020 National Health Care Fraud Takedown by the Department of Justice, a federal investigation that ***did not actually involve billing for telehealth services***. Instead, federal investigators allege that bad actors simply

used the Internet to create orders for orthotics and other devices and supplies. The expansion of telehealth services at issue in this Briefing is entirely separate from the conduct at issue in that case.

Nevertheless, to further support that the increased use of telehealth during the pandemic was not associated with unnecessary or inappropriate use of healthcare, we reviewed federal studies and conducted interviews with health systems. Between 2016 and 2020, the HHS Office of the Inspector General (OIG) and the General Accountability Office collectively conducted a total of four independent investigations of telehealth claims. All studies concluded that there was no evidence of inherent fraud.

In February 2021, the HHS-OIG released a statement confirming the lack of substantiated findings for telehealth fraud and distinguishing enforcement actions related to those Internet-based fraud schemes discussed above from concerns related to improper billing for telehealth services. CTeL's conversations with a sample of health systems across the United States in 2021 found evidence that telehealth enables timely, person-centered care while improving quality, reducing costs, and increasing care coordination, but did not yield evidence or concern of improper billing for telehealth services. Specifically, the health systems could not identify a change in health service volume resulting from the move from in-person to virtual health consults. The only exception noted was an increase of 85% in participation in medication management appointments which traditionally had a 50% non-compliance rate. In other words, there was no increase in health care services when patients had the option of accessing virtual care. Accordingly, there is no evidence that allowing providers to bill for evaluation and management services performed via telehealth has a more significant risk profile than traditional in-person medical services.

Disparities in Care

In the absence of aggregated national data, it is not feasible to quantify how the expanded use of telehealth will impact America's existing health disparities. At this time, there is insufficient information to determine whether increased use of telehealth impacted health disparities, but early findings suggest that telehealth improves access for non-White patients.

The expanded use of telehealth provides an opportunity to improve access by addressing challenges attributable to delayed care among low-income, urban communities. These challenges include transportation, leave from work, and child care. While telehealth has the potential to exacerbate health disparities among certain populations as a result of the additional technological infrastructure needed (including among households with limited access to technology devices or broadband and consumers with limited digital literacy), there are federal programs specifically designed to enhance broadband coverage and provide basic technologies for needy families. In addition, studies show that elderly populations, including Medicare patients, may be becoming more technologically competent over the past decade.

Upfront investments can help mitigate these potential disparities to ensure broader access to-and use of-telehealth by all populations:

- Financial investments to help providers and practices acquire, update, and effectively use telehealth;
- Computer literacy training tailored for distinct populations;
- Continued authorization of audio-only consults;
- Integration of telehealth platforms with language translation services;
- Ongoing approval for specialists to deliver telehealth services across state boundaries; and
- Accelerated expansion in broadband.

Conclusion

Early findings from Phase III will be available in Summer 2021, which we anticipate will provide evidence of lower costs, better access for vulnerable populations, and no concerns regarding increases in improper payments. The data can also be used to calculate the cost effectiveness of telehealth, and verify that its widespread expansion has been associated with appropriate use.

CTeL appreciates the committee's thoughtful consideration and looks forward to sharing its Phase III findings in the coming months. We hope to serve as a resource for the committee and encourage members and staff to reach out to our organization with any questions they may have.

Most sincerely,

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