Reimbursement for Telehealth Services

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Telehealth is a resource that can help reduce the burden on the United States healthcare system. The field of telehealth involves the use of both virtual and digital technology that allows healthcare, education, and other medically related services to be delivered from a distance (CCHP, 2019). It is a well-established system and allows a means of increasing access to healthcare in America, especially for those in rural and underserved communities (CCHP, 2019). While its popularity continues to grow, the reimbursement of it has many gaps, which is impeding the expansion of telemedicine (CCHP, 2019).

Policy Overview

The first reimbursements of telehealth by Medicare came in 1997 as part of the Balanced Budget Act and were again expanded upon in 2000 through The Benefits Improvement and Protection Act (Fathi, Modin, & Scott, 2017). Nearly 20 years have passed since any further changes have been made to the reimbursement policy regarding telehealth. In 2019, Medicare finally changed its reimbursement policy to reflect required changes, passed into law as H.R. 1892 – Bipartisan Budget Act of 2018 Public Law No. 115-123 (Bipartisan, 2018). However, it continues to be very limited. Per the amendments this law made to statute 1834(m) of the Social Security Act, Medicare will only reimburse specific services delivered by a live video feed and also places limitations on the types of healthcare providers that can provide the services (CMS, 2019). Furthermore, the CCHP (2019) explained that restrictions still also apply to the originating site, which is the physical location of the patient. Lastly, the service provided must be on the list of specific services and Current Procedural Terminology (CPT) codes to qualify for reimbursement (CMS, 2019).

To complicate the reimbursement process further, other changes in 2019 included the Centers for Medicare and Medicaid Services (CMS) expanding reimbursement so that remote communication technology and physiological monitoring was covered along with management of chronic diseases (NCTRC, 2019). Medicaid also has allowed reimbursement of telehealth, however, each state is responsible for the policies surrounding telehealth in regards to Medicaid (NCTRC, 2019). As explained by the NCTRC (2019), this has created a patchwork quilt of laws as the policies vary across the states, muddled further by specific limitations set forth by those states.

The multitude of policies and laws surrounding telehealth reimbursement is complicating a valuable resource. The goal within the US is to ensure healthcare is available in a better, less costly, more accessible platform. Part of that can be achieved through the use of telehealth. So many physicians and advanced practice healthcare providers are needed across various fields. They are needed in our emergency departments, hospitals, clinics, skilled nursing facilities, research labs, and so many other places. In the US alone, by 2020, experts say that the country will be short by more than 90,000 physicians, 130,000 by the year 2025 because there is more demand, but not as many people opting to be physicians along with other physicians retiring (Truscelli, 2016). If the shortages are so great, healthcare will suffer because it is likely that the cost and availability of having a healthcare provider in all of those fields will make it next to impossible. Thus, telemedicine can be a valuable tool to overcome those shortfalls.

Additionally, telehealth is also a method that can be used to bring healthcare to underserved populations, such as those within rural areas. Like with the individuals that do not want to take time off of work, others would have to take a day or two off to travel for an appointment as healthcare is limited in many of the rural areas in the country. In addition to that,

there is the expense itself of traveling. This population may put off going to see a physician for a long time because of those factors. With telehealth, these patients can access care quickly and at a much less expense and inconvenience to them. It can help prevent escalations of illness because telehealth will help enable them to reach out sooner (Truscelli, 2016).

Unfortunately, if providers and patients are unsure of the reimbursement of telehealth and find the process too difficult to navigate, many will choose not to do so. According to a survey completed in 2015, 55% of providers who did not use telehealth and 43% of those who did said reimbursement of telehealth services was a major barrier to using it (Harvey, Valenta, Simpson, Lyles, & McElligott, 2019). It is a disservice to telehealth, healthcare providers, and the people in the US if the reimbursement of telehealth services is not simplified.

Stakeholders

There is a range of stakeholders who are important to the reimbursement of telehealth. Those that are affected include patients, particularly those of underserved populations like rural areas, and a majority of healthcare providers, including physicians, psychologists, psychiatrists, social workers, pharmacists, nurses, nurse practitioners, and clinical nurse specialists. Healthcare organizations are also affected by the reimbursement of telehealth services as there is a service that can be provided to their patients, but because of concerns surrounding reimbursement, the service is underutilized. Decision-makers regarding telehealth reimbursement include policymakers, health insurance companies, and the CMS. A commonality between these stakeholders is their desire to increase the access patients have to healthcare and to improve that healthcare (IOM, 2012). Some, like the government and insurance companies or Medicare or Medicaid, however, focus additionally on wanting to control costs, but those providing the services want it to be profitable (IOM, 2012). As discussed

by the Institute of Medicine (2012), all of these needs must be met for telehealth to be a usable, effective service that is efficient.

Telehealth is a service that is needed and can improve health within the country, but it is not being used to its full advantage due to the various restrictions that surround reimbursement. With telehealth, healthcare can be provided remotely, bringing services to patients that may not otherwise have access, thus allowing the right care, at the right place and time to be delivered to them (Hollander et al., 2018). Withholding this valuable and efficient service from patients is detrimental to the healthcare they could be receiving and to their health. The focus of healthcare in this country is to be one that provides high-quality care and is value-based. By delivering a service such as telehealth, care delivery is carried out in a manner that is beneficial for patients and providers, while improving efficiency and maintaining or improving quality of care (Hollander et al., 2018).

The IOM's Standpoint

In 1996, a report by the IOM, *Telemedicine: A Guide to Assessing Telecommunications for Health Care*, was released (IOM, 2012). In this report, telehealth was assessed and found to be similar to other technologies in that it brought efficiency to healthcare (IOM, 2012). Furthermore, the IOM has stated that technology advances through services like telehealth are necessary to achieve better outcomes for patients and plays a central role in the redesign of healthcare (Fathi et al., 2017).

Telehealth has grown since that initial report by the IOM, with much research being dedicated to it, and technology continues to advance, allowing for more improvements (IOM, 2012). However, as the IOM (2012) wrote, barriers to its use continue to be an issue, and a major one is reimbursement. The IOM (2012) reported that reimbursements are very limited,

generally to non-metropolitan areas and further restricted by CPT codes. Reasons for these restrictions include a fear that telehealth will allow healthcare providers to abuse the system, or that it will be overutilized, driving up the cost of healthcare (IOM, 2012).

Various motivators need to be considered to overcome this barrier to telehealth. As suggested by the IOM (2012), adopting the practice of telehealth and having the services it can provide reimbursed can improve the quality of care to patients. Additionally, having too many restrictions on the reimbursement of telehealth is keeping it from expanding and being used to its true potential (IOM, 2012). Restricting reimbursement based on where both the patient and provider are have also caused a hindrance as it has brought fear to critical access hospitals and community health centers about being liable for the patients, especially in the case of medical malpractice (IOM, 2012). As explained by the IOM (2012), these fears are unfounded, as so far, other fears of the past have not come to light, such as abuse of the healthcare system.

Solutions to overcome the barrier of reimbursement have been discussed by the IOM. One suggestion was that telehealth simply needs to be treated like in-person healthcare, and just because a physician may appear on a screen, the patient is still going to see that provider (IOM, 2012). With telehealth, there are also no incentives for providers. If telehealth is properly supported through initiatives like changes to provider payments and training, telehealth will be embraced by providers (IOM, 2012). Perhaps one of the biggest solutions to overcoming the barrier of reimbursement is simply to show how telehealth can produce better care and patient outcomes, and provide higher quality of care with a lower cost in doing so (IOM, 2012).

Policy Options

As discussed as a possible solution by the IOM (2012), an option to overcoming the barrier of reimbursement with telehealth is to consider it to be like any other healthcare visit.

Telehealth should not be limited to certain areas, specific providers, or for set services. The use of telehealth should follow the same reimbursement scales as all other healthcare. There are instances in which it is better for a person to receive these services than none at all. An example given by Hollander et al. (2018) was how telehealth has been in use since the 1950s as it was a part of the space program. Astronauts in space did not have access to healthcare, yet through telehealth, they could receive care and services. This same concept needs to be applied to the many underserved populations within the US. Furthermore, specialty services cannot be provided in every area, including metropolitan ones, so it is essential that instead of restricting reimbursements of services via telehealth, it is a healthcare service available to everyone.

A con to allowing telehealth reimbursement to follow the same reimbursement schedule as all other healthcare services is that it may not save money as people may choose to use telehealth and still see providers in person. According to one study, only 12% of telemedicine visits replace office visits to a local provider (Ashwood, Mehrotra, Cowling, & Uscher-Pines, 2017). Additionally, nearly 90% of telehealth services provided were for a new service by patients who had already had a regular office visit (Ashwood et al., 2017). By lifting certain reimbursement restrictions, this could result in overutilization of services and increased costs, decreasing the efficiency of telehealth. However, with proper patient education on how to use telehealth, this can be overcome.

Nurse as a Change Agent

Nurses can influence telehealth and ways to achieve reimbursement for those services in many ways. Within healthcare, nurses are in a position to collaborate with others in addressing disparities within underserved communities, and telehealth is one way to do so (Fathi et al., 2017). Another way nurses can be change agents in telehealth is to stay informed and support

the initiatives that surround telehealth such as the reimbursement for services provided through that module (Fathi et al., 2017). Fathi et al. (2017) added that nurses are advocates of policy and need to practice to the fullest extent of their training and education to aid in the reform and campaign for nonrestrictive benefits for telehealth. Because of how each state can further define reimbursement for telehealth, it is also important that nurses are involved at the state level, advocating for change to health policy there, too (Fathi et al., 2017). Furthermore, nurses can address the educational needs patients will have about the use of telehealth to ensure that the use of telehealth is appropriate and timely (Fathi et al., 2017).

Factors of Influence

One of the major factors of influence on the policy that surrounds reimbursement of telehealth services is legislation. Reimbursement of telehealth services must be comparable to that of other healthcare services to ensure that telehealth and the benefits of it move into the common practice of healthcare (Fathi et al., 2017). This is necessary at both the national and state levels. While the Bipartisan Budget Act of 2018 has allowed some restrictions to be removed by Medicare, reimbursement still does not align with that for other services.

Another factor is to have the support of healthcare providers. Some providers are still holding back on using telehealth services for various reasons such as concerns with increased demand for their services and a loss of profit. Unfortunately, they are not recognizing the negative impact doing so has on underserved communities. Healthcare providers need to embrace change and accept a new way of providing healthcare. Doing so will help this nation meet its goal of its healthcare system being one that is value-based and as a result, achieve better health and better care at a lower cost (Fathi et al., 2017).

Lastly, the payers of insurance and health insurance providers need to recognize the positive impacts telehealth can have on the health of those they insure. If properly implemented and reimbursed in a simple manner, telehealth can lower healthcare costs, saving these industries money. Various studies have shown the amount of healthcare dollars that can be saved yearly. One particular report completed by The Rural Broadband Association found that the national average of cost savings within hospitals was over $20,000 per facility when telehealth was utilized (URAC, 2017). Telehealth has also been beneficial in reducing hospital readmissions, which costs Medicare over $26 billion every year (URAC, 2017).

Conclusion

While after 20 years changes were made within the policies surrounding reimbursement for telehealth services, these still leave a complicated system to navigate for both providers and consumers of telehealth services. By changing the reimbursement policy to align with that of other healthcare services, telehealth will become better utilized and help this nation become one of a value-focused system. Additionally, patients will receive higher quality of care that can be provided anywhere and for all. With proper implementation of telehealth and clear reimbursement standards, healthcare costs can be lowered significantly. All healthcare providers play a crucial role in helping to achieve this in advocating for changes within the legislation to ensure that patients can receive high-quality care that is reimbursed without difficulty.

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