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Understanding The Case For Telehealth Payment Parity

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In the wake of the COVID-19 pandemic, telehealth use surged as a result of Medicare and private payers loosened payment restrictions. While there is bipartisan support from

lawmakers, administrators, and clinicians for the continued use of telehealth following the pandemic, debate about multiple implementation issues remains, importantly: Should telehealth continue to be reimbursed at the same rate as in-person care?

The subject of telehealth parity is not new. Existing parity laws in 43 states and the District of Columbia require commercial insurers to cover telehealth. However, coverage parity is not the same as payment parity—the latter requires insurers to pay for telehealth and in-person services at equal rates. While only a few states have payment parity laws for telehealth, payment parity is now the focus of numerous state bills. In addition, telehealth payment parity for the Medicare program was recently discussed at a congressional hearing and in the Medicare Payment Advisory Commission's recent report on telehealth.

The issue of telehealth payment parity gained national attention when the Centers for Medicare and Medicaid Services (CMS) used its waiver authority to establish payment parity for in-person, video, and audio-only telehealth during the COVID-19 pandemic; most commercial insurers followed suit. However, it is unclear whether payment parity will continue, and for what kinds of telehealth visits, after the public health emergency. In fact, CMS has already announced that Medicare will not cover audio-only telehealth for evaluation and management visits after the public health emergency and may decide to pay for telehealth visits at a lower rate than was used during the pandemic.

There are several reasonable arguments against payment parity for telehealth. First, relative to in-person care, it is plausible that telehealth requires less clinical effort. Second, care delivered via telehealth may have less value than in-person care, in the sense that it may be more likely to be ineffective or inefficient. Third, telehealth may have a greater potential for overuse than does in-person care. Finally, the practice expenses associated with delivering telehealth may be lower than in-person care. While these arguments are valid, compelling counterarguments are worthy of discussion and are the focus of this blog post.

Does Telehealth Require Less Clinical Effort?

While numerous factors can impact the amount of clinical effort spent by clinicians on outpatient visits, the mode of care delivery is not one of them. As outlined in the 2021 evaluation and management guidelines, clinical effort for an outpatient visit is defined by the complexity of the patient's diagnosis, volume of data reviewed, risk of management options, and time spent in the patient's care. These four factors have long been used to determine reimbursement for evaluation and management visits and are independent from mode of delivery. In fact, according to the 2021 evaluation and management

guidelines, clinicians are not even required to perform and document a physical exam when they are selecting billing levels, unless medically appropriate. While the physical exam is essential for some diagnoses, comparable levels of clinical effort may be necessary for visits that do not involve a physical exam.

Does Telehealth Propagate Low-Value Care?

While low-value care can exist for both in-person and telehealth visits, the mode of delivery should not be used to make a blanket distinction between high- and low-value care. Undoubtedly, for certain diagnoses, clinicians can provide higher-value care through in-person visits. However, clinicians and their professional societies should guide decisions about the clinical appropriateness of telehealth. For instance, the American Urological Association guidelines state that the evaluation of patients with erectile dysfunction requires a physical examination. Although it does not prohibit telehealth for erectile dysfunction management, this guideline does imply that urologists should consider combining in-person care with telehealth in the care of this condition. Insurers that create guardrails for telehealth without clear evidence for what is clinically appropriate and inappropriate will frustrate both clinicians and patients who receive surprise bills because their insurers cover some, but not all, diagnoses.

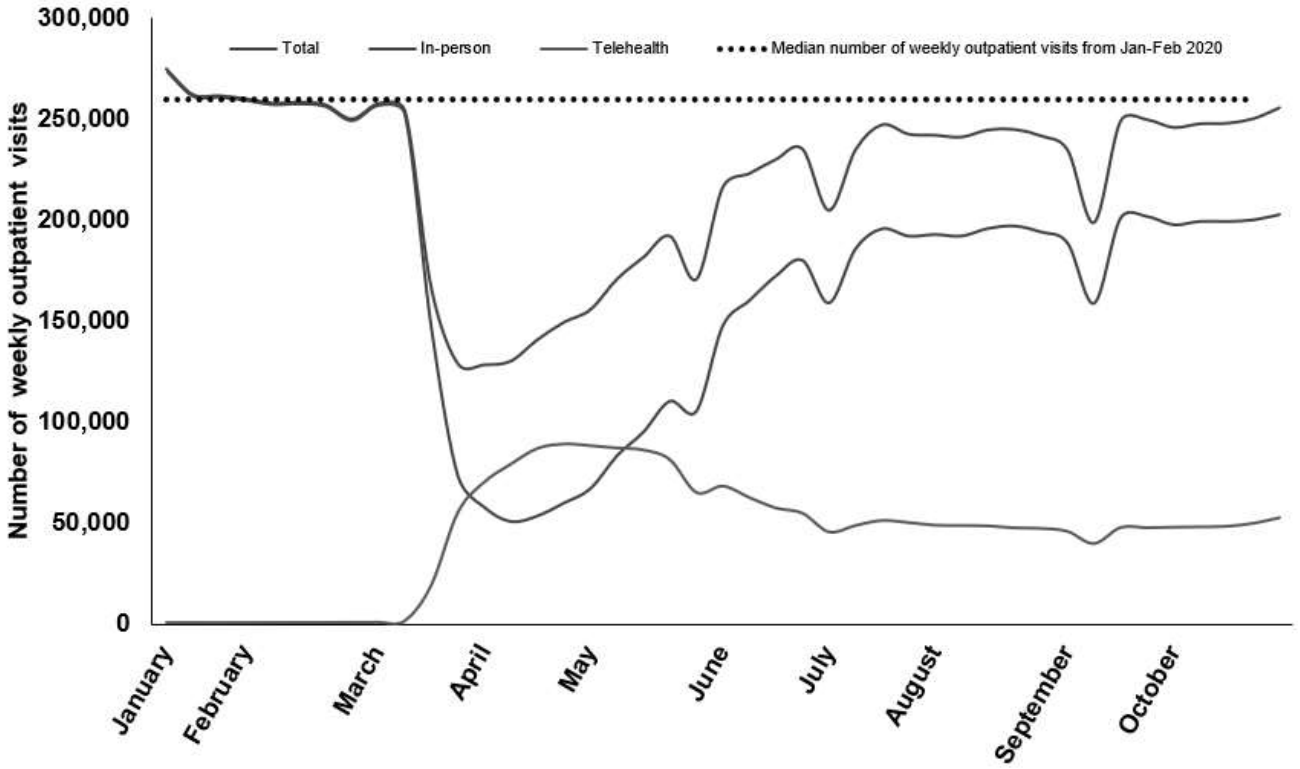
Additionally, reducing or eliminating payment for audio-only telehealth services over value concerns overlooks the key reasons some patients prefer, or are required to use, audio-only telehealth. Approximately 50 percent of telehealth visits during the early months of the COVID-19 pandemic were conducted over the phone, with higher frequency of use among older, minority, non-English speaking, and rural patients. These groups likely chose audio-only telehealth because they lacked digital access or the technical ability to perform video visits, not because they believed better care comes over the phone. Additionally, the medical content delivered via phone when patients have difficulty connecting during a scheduled video visit is unlikely to differ between the two media. Rather than incentivizing practices in underserved communities to develop infrastructure for video visits, elimination of audio-only telehealth payment parity may discourage such providers from investing in telehealth infrastructure at all, leaving hard-to-reach patients with no option for remote care.

Does Telehealth Lead To Overuse?

Although there are obvious concerns that telehealth will lead to overuse, there is little compelling evidence to suggest that continuing payment parity following the pandemic's end will lead to runaway health care spending. In my evaluation of Blue Cross Blue Shield

of Michigan claims from January 2020 through October 2020, telehealth rose from zero to about half of all outpatient visits at the start of the pandemic, but it settled at about 21 percent by October. While telehealth use is now 20 times higher than it was prior to the pandemic, the total number of weekly outpatient visits has not exceeded pre-pandemic levels; in other words, telehealth has served as a substitute for in-person care (exhibit 1). While fraud, abuse, and overuse are valid concerns, they can be mitigated by aligning reimbursement for video- and audio-only visits with the same evaluation and management billing and documentation criteria required for in-person visits. CMS can use separate modifier codes for video-based and audio-only telehealth to monitor and investigate outliers for fraud, abuse, and overuse.

Exhibit 1: Number of weekly total, in-person, and telehealth outpatient visits from January through October 2020, Blue Cross Blue Shield of Michigan



Source: Author's analysis. Note: Number of weekly outpatient visits was determined using Blue Cross Blue Shield of Michigan preferred provider organization claims from the week of January 5, 2020 through October 31, 2020. Median number of weekly outpatient visits prior to the COVID-19 pandemic is equal to 259,224 and was determined using data from the week of January 5, 2020 through the week of February 23, 2020.

Does It Cost Clinicians Less To Deliver Telehealth?

While in theory it may cost less for clinicians to deliver telehealth compared to in-person care, in reality, telehealth does not always reduce practice expenses. CMS sets payment rates for outpatient visits based on the estimated costs of three primary inputs: clinical effort, malpractice insurance, and practice expenses. Malpractice expenses do not differ between telehealth and in-person visits and, as I have argued in this post, neither does clinical effort. While the practice expense of performing telehealth may be lower for clinicians employed by telehealth-only companies that do not have a brick-and-mortar practice, this is not the case for clinicians who perform both in-person and telehealth visits. Hybrid clinicians will continue to employ non-physician staff (for example, nurses, clerical) to coordinate pre- and post-visit care, and will continue to pay fixed expenses to maintain their brick-and-mortar practices. The costs saved by reducing the use of exam tables, gloves, and other supplies needed for in-person care are offset by the expense associated with telehealth subscription fees, digital device maintenance, and the incremental staff time involved in teaching patients how to connect. Furthermore, in comparing the average face-to-face time spent between patient and surgeon during video and in-person visits, we found that surgeons were spending more time on the video visits, which challenges claims that clinicians can use telehealth to increase daily patient volume and reduce the marginal cost of telehealth visits.

Looking Ahead

As policy makers determine the future of telehealth payment policy, CMS, state Medicaid programs, and commercial insurers should wait for sufficient data to accurately estimate the impact of telehealth on access, costs, and quality. These organizations should temporarily continue payment parity for video and audio-only telehealth after the public health emergency to allow telehealth to flourish outside of the pandemic. Thereafter, robust research can be used to determine whether their investment in telehealth improves care for beneficiaries and whether or not payment rates are aligned with the costs of delivering telehealth. Payment parity is particularly important for small practices and those located in underserved communities, who may not have the financial means to offer telehealth if reimbursement is substantially lower. Telehealth has the potential to modernize US health care, reduce health care spending, improve access to care, and enhance the patient experience. Policies that prematurely reduce or eliminate payments for telehealth, including audio-only telehealth, will only diminish its use and its potential.

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