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SOCIAL DISTANCING WITH YOUR DOCTOR: THE PROMISE OF TELEMEDICINE IN MEDICARE AND MEDICAID, AND HOW TO PAY FOR IT

*Jacob Hauschild**

Long have practitioners and patients alike envisioned a mode of health care delivery wherein the treating physician need not be physically present. Those visions rapidly manifested during the year 2020, when the novel COVID-19 coronavirus swept across the world, disrupting the ability of patients to visit with their doctors face-to-face.

Yet a solution to this problem was depicted with startling accuracy almost sixty years earlier, on a 1962 episode of the futuristic ABC sitcom, *The Jetsons*.¹ When young Elroy Jetson told his mother that he may have contracted the “Venusvirus,” the family doctor promptly teleconferenced in by video, inspected Elroy’s mouth, and charged the family \$100 for his services.² Though the program’s laugh track suggests that this “home visit” was comically unrealistic in 1962, the widespread utilization of *telemedicine*,³ as it was later coined, was far more sobering in 2020.

The COVID-19 pandemic forced significant changes in how patients engaged with their health care providers. Because of

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1. *The Jetsons: Uniblax* (ABC television broadcast Nov. 25, 1962).

2. *Id.*

3. This note uses the terms “telemedicine” and “telehealth.” Though some use the term “telehealth” to refer to a broad set of patient services delivered remotely and “telemedicine” to mean a subset of telehealth, referring only to clinical services delivered remotely, this note does not intend to create any meaningful distinctions between the choice of one term over the other. See *What’s the Difference Between Telemedicine and Telehealth?*, AM. ACAD. OF FAMILY PHYSICIANS (Mar. 2020), <https://www.aafp.org/news/media-center/kits/telemedicine-and-telehealth.html#:~:text=Telehealth%20is%20different%20from%20telemedicine,to%20remote%20non%2Dclinical%20services>.

widespread social distancing practices, providers in March 2020 began cancelling non-essential appointments, converting those appointments to telehealth appointments when possible.⁴ In some states, governments even ordered that non-essential appointments and procedures be delayed.⁵ In all, weekly telemedicine utilization increased twenty-three-fold during the early stages of the national health emergency.⁶

This increased utilization of telemedicine was only possible because of changes to how providers were compensated for care delivered during this time. The United States predominantly uses a fee-for-service reimbursement system, wherein health care providers only deliver care that is pre-negotiated and billable to an insurer, which guarantees the provider payment for care given.⁷ Generally, providers fear that in the delivery of telemedicine, significant amounts of virtual care gets lost, not fitting within any specific “code” that can be billed to the payer.⁸ Therefore, practitioners who utilize telemedicine risk doing so at the cost of lost revenue whenever that care doesn’t fit within a reimbursement code, despite the improved health care outcomes telemedicine offers for patients like Elroy.⁹ Because of the importance of remote care during the 2020 pandemic, many states and the federal government accommodated important changes to these codes—waiving existing restrictions and even offering grants to help health systems transition to new forms of care delivery.¹⁰ However, these changes are temporary, and coverage

4. See, e.g., *Information for Patients Regarding Non-Essential Office Appointments, Surgeries and Procedures*, U. HOSP. (last visited Apr. 17, 2020), <https://www.uhhospitals.org/healthcare-update/non-essential-office-appointments>.

5. *Fact Sheet: State Action Related to Delay and Resumption of “Elective” Procedures During the COVID-19 Pandemic*, AM. MED. ASS’N (last visited Apr. 17, 2020), <https://www.ama-assn.org/system/files/2020-04/state-elective-procedure-chart.pdf>.

6. Sadiq Patel et al., *Variation in Telemedicine Use and Outpatient Care During the COVID-19 Pandemic in the United States*, 40 HEALTH AFF. 349, 351 (2021).

7. See discussion *infra* Part I.B.

8. See discussion *infra* Part II.C(i).

9. *Id.*

10. See Mike Miliard, *FCC Announces First Hospitals to Win COVID-19 Telehealth Program Funding*, HEALTHCARE IT NEWS (Apr. 16, 2020, 5:01 PM), <https://www.healthcareitnews.com/news/fcc-announces-first-hospitals-win-covid-19-telehealth-program-funding> (describing federal agency telehealth funding implemented during the COVID-19 pandemic).

gaps will likely reemerge once the threat of COVID-19 lessens and telemedicine reimbursement restrictions are put back in place.¹¹

This note explores modern telemedicine and provider reimbursement models within Medicare and Medicaid to identify the primary barriers to greater sustained telemedicine utilization in these programs and to advocate for a solution to overcome those deficiencies. The first section discusses the three modalities of telemedicine and the ways in which Medicare and Medicaid reimburse providers for telemedicine delivery. The second section analyzes the shortcomings in Medicare and Medicaid reimbursement models and considers how alternative models may better incentivize use of this technology. This note argues that value-based reimbursement models better capture the benefits of telemedicine and allow providers to be adequately reimbursed for efficient and effective telehealth care within the Medicare and Medicaid programs.

I. BACKGROUND

Telemedicine is a mechanism through which modern technologies can be utilized to improve public health. The first part of this section discusses how telehealth services have developed over time, discusses its various modalities, and presents examples of telemedicine technologies in their most modern forms. The latter part of this section presents an overview of how Medicare and Medicaid reimburse for telehealth delivery, alternative payment models utilized within those public programs, and how the COVID-19 pandemic forced changes in telemedicine reimbursement.

A. WHAT IS TELEMEDICINE?

Telemedicine, or telehealth, takes many forms, but it can broadly be understood as “[t]he delivery of health care services . . . by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and

11. *But see* Bob Kocher, *COVID-19 is Normalizing Telehealth, and That’s a Good Thing*, FAST COMPANY (Apr. 16, 2020), <https://www.fastcompany.com/90490988/covid-19-is-normalizing-telehealth-and-thats-a-good-thing> (arguing that, post-pandemic, telehealth will remain an integral part of healthcare).

injuries”¹² Modern health care providers are not the first to integrate new technologies into their practices. Rather, delivering care to patients in remote locations via telemedicine has long been a policy goal of the American health care system.

i. The development of telehealth delivery in the United States

Providers have attempted to improve health care access via telemedicine for over a century. The first documented use of telehealth preceded *The Jetsons* by almost seventy years, when a doctor in 1897, diagnosed a child with croup¹³ after hearing the child cough over a telephone consultation.¹⁴ In the century that followed, telehealth was primarily utilized to offer basic, usually diagnostic, services to individuals in work locations and conditions that did not allow them to utilize conditional health care services. For example, the United States military, NASA, stations in the Antarctic, and offshore oil rigs have all utilized technology that allows their workers to receive health care services despite their isolated locations.¹⁵ Perhaps the most successful telehealth initiative has occurred within the Department of Veterans Affairs (VA).¹⁶ VA hospitals have utilized technology such as video and messaging devices to collect data from patients for diagnostic purposes so that patients need not leave their homes.¹⁷ Since implementing this program in 2003, the VA has reported a 35% reduction in hospital admissions, along with a 59% reduction in total inpatient days of care.¹⁸

12. WORLD HEALTH ORG., TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES 9 (2nd vol. 2010), https://www.who.int/goe/publications/goe_telemedicine_2010.pdf.

13. *Croup*, MAYO CLINIC (Apr. 11, 2019), [https://www.mayoclinic.org/diseases-conditions/croup/symptoms-causes/syc-20350348#:~:text=Croup%20refers%20to%20an%20infection,and%20bronchial%20tubes%20\(bronchi\)](https://www.mayoclinic.org/diseases-conditions/croup/symptoms-causes/syc-20350348#:~:text=Croup%20refers%20to%20an%20infection,and%20bronchial%20tubes%20(bronchi)) (“Croup refers to an infection of the upper airway, which obstructs breathing and causes a characteristic barking cough.”).

14. Gabrielle Lee, *A Telehealth Technicality: Pennsylvania’s Outdated Insurance Reimbursement Policies Deter Investment in Modern Telehealth Technology*, 15 PITT. J. TECH. L. POL’Y 115, 117 (2014) (citing ADAM WILLIAM DARKINS & MARGARET ANN CAREY, TELEMEDICINE AND TELEHEALTH: PRINCIPLES, POLICIES, PERFORMANCE, AND PITFALLS 7 (2000)).

15. Lee, *supra* note 14, at 118.

16. See *How Telehealth Works at VA*, U.S. DEP’T OF VETERANS AFF., <https://telehealth.va.gov/how-telehealth-works-va>.

17. Avery Schumacher, *Telehealth: Current Barriers, Potential Progress*, 76 OHIO ST. L.J. 409, 410 (2015).

18. Robert Janek, *Need Help Managing Your Patients’ Chronic Disease at Home? Consider VNA of Ohio TeleHealth*, MD NEWS (Feb. 17, 2014),

The utilization of telehealth services in our Medicare and Medicaid programs is, however, less storied. In the early 1990s, health care access advocates promoted the growth of “hub-and-spoke” networks, where patients could utilize otherwise prohibitively expensive videoconferencing systems in one of many patient sites (i.e. the “spokes”) to connect with specialty caregivers in centralized locations (i.e. the “hub”).¹⁹ After these networks were in place, advocates focused on state-level legislation to install Medicaid reimbursement for this care.²⁰ In 1997, the first telehealth Medicare law was enacted at the behest of then-Vice President Gore, who had identified telehealth as an area of priority in the advancement of the National Information Infrastructure.²¹ Since then, telehealth policy within Medicare and Medicaid has evolved to meet a variety of modern concerns: a shortage of providers and related concentration of providers in urban areas, rising health care costs, and public health crises such as the opioid epidemic.²²

ii. Ways in Which Telemedicine is Used Today

a. The Three Modalities of Telehealth Technology

There are three distinct modalities of telehealth delivery: *synchronous*, *asynchronous*, and *remote patient monitoring*. The distinctions between these modalities are important because

<https://mdnews.com/need-help-managing-your-patients%E2%80%99-chronic-disease-home-consider-vna-ohio-telehealth>, (“VNA of Ohio’s statistics for its TeleHealth patients show similar outcomes: 19.85% reduction in emergency care events, 29.78% reduction in inpatient events, and 4.25% reduction in 30-day readmits with same diagnosis.”).

19. Thomas Nesbitt & Jana Katz-Bell, *History of Telehealth, UNDERSTANDING TELEHEALTH*, <https://accessmedicine.mhmedical.com/content.aspx?bookid=2217§ionid=187794434#1158358711>.

20. *Id.*; *see, e.g.*, Telemedicine Development Act of 1996, Cal. Bus. & Prof. Code § 2290.5 (West).

21. U.S. DEPT. OF COMMERCE, TELEMEDICINE REPORT TO CONGRESS, EXECUTIVE SUMMARY (Jan. 31, 1997), <https://www.ntia.doc.gov/legacy/reports/telemed/cover.htm> (last visited Jan. 21, 2020).

22. *See* LEGISLATIVE SUMMARY: BALANCED BUDGET ACT OF 1997 MEDICARE AND MEDICAID PROVISIONS, 1, 44, https://innovation.cms.gov/files/migrated-medicare-demonstration-x/cc_section4016_bba_1997.pdf (last visited Dec. 1, 2019); *see also* Mei Wa Kwong, *Telehealth and Public Programs - Evolution of Telehealth Policy in Medicare and Medicaid*, 15 J. HEALTH & BIOMEDICAL L. 7 (2019).

providers receive reimbursement for the utilization of some technologies, but not others, by private insurers and Medicare and Medicaid policies.²³

Synchronous technology involves providers meeting with patients virtually—for example, via live video—in order to provide medical advice.²⁴ Because this technology has existed for quite a long time, and because the utilization of that technology is fairly easy to conceptualize, the utilization of synchronous care is already fairly widespread, with many hospital systems offering communication of this sort to all patients.²⁵

Asynchronous technology, sometimes called “*store-and-forward*” technology, does not require that a provider meet with a patient virtually or have a scheduled appointment with the patient.²⁶ Instead, it allows the patient to prerecord data by taking pictures, recording videos, or inputting data on her own time and transmitting that medical information to the provider via a secure, online communication.²⁷ The provider later reviews the information and advises the patient accordingly, either via that same online technology (e.g. email), or via a phone call.²⁸ This modality of telehealth includes basic uses such as a patient taking a picture of a rash and uploading it for her doctor’s review, but it also includes more complex health care delivery, such as providers communicating the results of services like “x-rays, echocardiograms and other radiographic images” without requiring a follow-up, in-person appointment.²⁹ Asynchronous telehealth is particularly beneficial for diagnosis and treatment decisions, as well as for patient follow-ups as part of a recovery plan.³⁰

23. *Infra* Part I.B.(i)–(ii); *see also* Schumacher, *supra* note 17, at 417.

24. Center for Connected Health Policy, *About Telehealth: Live Video (synchronous) or Real-Time Interaction*, PUBLIC HEALTH INSTITUTE, <https://www.cchpca.org/about/about-telehealth/live-video-synchronous> (last visited Mar. 4, 2021).

25. *Cf. id.*

26. *See* Center for Connected Health Policy, *About Telehealth: Store-and-Forward (asynchronous)*, PUB. HEALTH INST., <https://www.cchpca.org/about/about-telehealth/store-and-forward-asynchronous> (last visited Mar. 4, 2021).

27. *Id.*

28. *Id.*; *see also* Schumacher, *supra* note 17, at 416.

29. HEALTH POLICY INST. OF OHIO, LOOKING AHEAD: UNDERSTANDING TELEHEALTH IN OHIO 15 (2013), https://www.healthpolicyohio.org/wp-content/uploads/2014/06/HPIO_Telehealth_Brief.pdf.

30. *Id.*

Finally, *Remote Patient Monitoring* (RPM) can be viewed as either separate from or a subset of the asynchronous modality. RPM utilizes passive technology, such as sensors or other monitoring equipment, that collects medical data and securely transmits that data to an external monitoring center.³¹ That data is then monitored remotely by providers, who can notify patients if certain health metrics become problematic.³² Such passive monitoring allows providers to develop a more complete understanding of a patient's status; for example, a provider can improve health care outcomes for her patients by observing how a patient's blood pressure or insulin levels may vary at different parts of the day.³³ Though RPM is usually used for chronic care management, emerging technologies with a variety of sophisticated measuring tools may increase the affordability of these devices and allow them to be more widely utilized in the delivery of preventative care.³⁴

b. Modern Applications of Telemedicine Technology

While health systems have seen impressive increases in telemedicine utilization since the beginning of the COVID-19 pandemic,³⁵ the growth in this area has largely been limited to the synchronous modality due to the ubiquity of audio and video telecommunications systems, as well as temporary reimbursement

31. Kwong, *supra* note 22, at 8.

32. See JEFF ELTON & ANNE O'RIORDAN, HEALTHCARE DISRUPTED: NEXT GENERATION BUSINESS MODELS AND STRATEGIES 127–28 (2016) (arguing that future caregivers must prioritize meeting patients where they are, rather than relying on patients to physically come to the clinic).

33. Michael W. King, *Telemedicine: Game Changer or Costly Gimmick?*, 95 DENV. L. REV. 289, 301–02 (2018).

34. See, e.g., Abu B. Suleiman, *The untapped potential of Telehealth*, 61 INT'L J. MED. INFORMATICS 103 (2001) (observing higher health outcomes in Malaysia after telemedicine was applied in preventative care).

35. Seema Verma, *Early Impact of CMS Expansion of Medicare Telehealth during COVID-19*, HEALTH AFFAIRS (July 15, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/> (noting that telemedicine visits have increased from approximately 13,000 Medicare beneficiaries a week before the public health emergency to nearly 1.7 million a week in the pandemic's early stages); Kat Jercich, *Vast Majority of Specialists Increased Use of Telehealth Tech During COVID-19 Pandemic*, HEALTHCARE IT NEWS (Aug. 26, 2020, 2:02 PM), <https://www.healthcareitnews.com/news/vast-majority-specialists-increased-use-telehealth-tech-during-covid-19-pandemic> (reporting that 79% of specialists have increased their telemedicine utilization during the COVID-19 pandemic); Patel et al., *supra* note 6 (finding a twenty-three-fold increase in telemedicine utilization since March, 2020).

modifications and guidance given by CMS which were limited in scope.³⁶ Notwithstanding, medical device companies evidently expect other modalities to be more widely used in the future, a trend that began before the pandemic.³⁷ Emerging technologies—some which are only available when prescribed by a physician, and others which are sold direct-to-consumer—allow patients to radically alter the way in which they receive care and maintain their wellbeing. Whether an individual needs to monitor her blood pressure throughout the day,³⁸ measure and track her glucose levels,³⁹ manage her atrial fibrillation,⁴⁰ track her

36. CNTRS. FOR MEDICARE & MEDICAID SERV., *Medicare Telemedicine Health Care Provider Fact Sheet* (Mar. 17, 2020), <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet> (indicating that providers seeking reimbursement by Medicare “must use an interactive audio and video telecommunications system that permits real-time communication”); *but see* CNTRS. FOR MEDICARE & MEDICAID SERV., *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance (CHIP) Agencies* (Jan. 6, 2021), <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> (providing guidance to states that each state Medicaid program can utilize “telephonic, video technology commonly available on smart phones and other devices” to deliver telemedicine).

37. *See, e.g.*, Alicia Phaneuf, *Latest Trends in Medical Monitoring Devices and Wearable Health Technology*, BUS. INSIDER (Jan. 11, 2021, 11:48 AM), <https://www.businessinsider.com/wearable-technology-healthcare-medical-devices>; Fortune Business Insights, *mHealth Apps Market to Rise at 21.1% CAGR till 2026; Increasing Number of Novel Products Will Aid Market Growth, says Fortune Business Insights*, GLOBENEWSWIRE (Jan. 30, 2020, 01:21 PM), <https://www.globenews0/1977213/0/en/mHealth-Apps-Market-to-Rise-at-21-1-CAGR-till-2026-Increasing-Number-of-Novel-Products-Will-Aid-Market-Growth-says-Fortune-Business-Insights.html>; Omdia, *Personalized Technology Driving \$5 Billion Growth Wave in Personal Health Device Market*, INFORMATECH (Jun. 11, 2019), <https://technology.informa.com/614865/personalized-technology-driving-5-billion-growth-wave-in-personal-health-device-market-ihs-markit-says#:~:text=Personalization%20will%20be%20a%20primary,to%20the%20latest%20research%20from>.

38. *BPM Core*, WITHINGS, <https://www.withings.com/us/en/bpm-core> (last visited Feb. 8, 2021).

39. *iHealth Smart Wireless Gluco-Monitoring System*, IHEALTH LAB, INC., <https://ihealthlabs.com/products/ihealth-smart-gluco-monitoring-system> (last visited Feb. 8, 2021).

40. *KardiaMobile*, ALIVECOR, <https://www.alivecor.com/kardiamobile/> (last visited Feb. 8, 2021).

blood oxygen saturation during sleep,⁴¹ monitor her brain activity,⁴² detect her fertility window,⁴³ or even conduct a basic medical examination,⁴⁴ portable and affordable technology now exists which makes unnecessary a visit to the doctor's office. The availability of these new technologies clearly demonstrates telemedicine's potential to improve patient outcomes. The market has also acknowledged this as an opportunity for growth: 2020 was marked by a variety of mergers and acquisitions within the telehealth sector,⁴⁵ and the telehealth market is anticipated to reach almost \$200 billion in the next five years.⁴⁶ Even the direct-to-consumer wearable medical technology market is estimated to be worth almost \$35 billion.⁴⁷

B. MEDICARE AND MEDICAID REIMBURSEMENT FOR TELEMEDICINE

Even with modern advancements in telehealth technology, one essential component is required for providers to utilize this technology in their routine practice: reimbursement. Regardless of the availability of health care technologies, such technologies

41. *ScanWatch*, WITHINGS, <https://www.withings.com/us/en/scanwatch> (last visited Feb. 8, 2021).

42. *Muse*, INTERAXON INC., <https://choosemuse.com> (last visited Feb. 8, 2021).

43. *Ava*, AVA SCIENCE INC., avawomen.com (last visited Feb. 8, 2021).

44. *TytoCare*, TYTOCARE LTD., <https://www.tytocare.com>, (last visited Feb. 8, 2021).

45. See, e.g., Heather Landi, *Telehealth Leader Teladoc to Buy Livongo in \$18.5B Deal*, FIERCE HEALTHCARE (Aug. 5, 2020, 11:30 AM), <https://www.fiercehealthcare.com/tech/teladoc-livongo-plan-to-merge-18-5b-deal>; Fred Pennic, *SPAC Merges with 2 Telehealth Companies to Form Public Digital Health Company in \$1.35B Deal*, HITCONSULTANT (Nov. 23, 2020), <https://hitconsultant.net/2020/11/23/spac-telehealth-merge-form-digital-health-company/#.YCAN7ehKg2w>.

46. ReportLinker, *The Global Telehealth/Telemedicine Market is Expected to Grow at a CAGR of 37.7% During the Forecast Period, to Reach USD 191.7 Billion by 2025 from an Estimated USD 38.7 billion in 2020*, YAHOO! FINANCE (Nov. 23, 2020), <https://finance.yahoo.com/news/global-telehealth-telemedicine-market-expected-100800843.html>

47. Emergen Research, *Medical Wearable Market Size Worth USD 34.89 Billion by 2027 Growing at a CAGR of 21.5%*, GLOBENEWSWIRE (Jan. 11, 2021, 6:03 AM), <https://www.globenewswire.com/news-release/2021/01/11/2156047/0/en/Medical-Wearable-Market-Size-Worth-USD-34-89-Billion-by-2027-Growing-at-a-CAGR-of-21-5-Emergen-Research.html>.

will only be utilized if providers prescribe them—that is, if payers agree to pay for them.⁴⁸ Ultimately, if a provider does not get paid for the care she delivers, she will find ways to deliver that care in a way that will be reimbursable, even at the cost of those many public health benefits.⁴⁹ Health care has traditionally been reimbursed through a fee-for-service methodology—that is, on an incident-by-incident basis, wherein each particular service must be represented by a pre-negotiated reimbursement “code” in order for a provider to receive payment from a payer.⁵⁰ So for telehealth services to be reimbursable in Medicare or Medicaid, pre-negotiated telemedicine codes must be promulgated by the Centers for Medicare & Medicaid Services (CMS).⁵¹

i. Reimbursement in Medicare

a. Telemedicine Reimbursement

Medicare is a federal health care program which primarily covers elderly and disabled individuals and which reimburses providers, except through certain experimental programs,⁵² on a fee-for-service basis.⁵³ Because it is a federal program, Medicare

48. Bob Herman, *Virtual Reality: More Insurers are Embracing Telehealth*, MODERN HEALTHCARE (Feb. 20, 2016), <https://www.modernhealthcare.com/article/20160220/MAGAZINE/302209980/virtual-reality-more-insurers-are-embracing-telehealth> (“More than half of the doctors surveyed said a lack of payment was the top barrier to using telehealth in their practices.”).

49. See Hidden Brain, *Slaying the ‘Fee-for-Service Monster’ of American Healthcare*, NAT. PUB. RADIO (Sept. 7, 2020, 4:00 PM), <https://www.npr.org/2020/09/02/908728981/slaying-the-fee-for-service-monster-of-american-healthcare> (“You’re rewarding people doing things to other people. And actually, in many cases, you’re rewarding that regardless of whether it actually improves a person’s health. So as long as you do a lot of procedures, as long as you poke and prod patients and do more colonoscopies or operations or administer expensive chemotherapeutic agents, the more you do to them, the more money you make.”).

50. *What is Medical Coding?*, AAPC, <https://www.aapc.com/medical-coding/medical-coding.aspx> (last visited Mar. 6, 2021).

51. David E. Beck & David A. Margolin, *Physician Coding and Reimbursement*, 7 OSCHSNER J. 8, 10 (2007).

52. See generally *CMS Innovation Center*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://innovation.cms.gov/>.

53. See, e.g., Louise Norris, *How Does a Doctor’s Participation in Medicare Affect Reimbursement?*, THE MEDICARE RES. CTR. (October 15, 2018), <https://www.medicareresources.org/faqs/how-does-medicare-reimbursement-work/>.

reimbursement does not vary from state to state.⁵⁴ Instead, it is governed by Social Security Act § 1834(m), which restricts reimbursement for telemedicine in three important ways. These restrictions limit the types of services that can be delivered through telemedicine, impose geographical restrictions on services to patients, and require that patients receive telemedicine care at an “originating site.”⁵⁵

First, Medicare only reimburses for synchronous communications,⁵⁶ despite the fact that it insures a relatively immobile population that struggles to access healthcare.⁵⁷ This means that, for the most part, providers have no monetary incentive to utilize asynchronous and RPM technology with their Medicare-enrolled patients.

Second, § 1834(m) limits the patients that can receive telemedicine based on geography. Specifically, it requires that a patient receive health care in a Health Professional Shortage Area—a geographical area that the Health Resources and Services Administration designates as having a shortage of providers for either an entire population, specific population groups, or a certain subtype of facility.⁵⁸ Nearly 70% of these shortage areas are in rural America.⁵⁹ Since the large majority of urbanites do not live within a Health Professional Shortage Area, many Medicare beneficiaries are effectively disqualified from receiving telemedicine services from their doctors.

54. *But cf.* Katherine W. Dandy et al., *The Case for Telemedicine: How Telehealth Solutions Can Reduce Legal Risk While Improving Patient Access and Lowering Health Care Costs*, 2018 N.Y. STATE BAR J. 39, 42 (noting that pilot programs exist in Alaska and Hawaii that vary traditional Medicare reimbursement models).

55. King, *supra* note 33, at 308.

56. Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. No. 106-554, 114 Stat. § 2763 (2000).

57. Rebecca Adams, *Experts: Medicare Changes Promising but Barriers Hard to Overcome*, THE COMMONWEALTH FUND (Oct. 22, 2010), <https://www.commonwealthfund.org/publications/newsletter-article/experts-medicare-changes-promising-barriers-hard-overcome>.

58. *What is a Health Professional Shortage Area (HPSA)?*, HEALTH RES. & SERVS ADMIN., <https://bhwh.hrsa.gov/workforce-shortage-areas/shortage-designation> (last visited Mar. 6, 2021).

59. Bureau of Health Workforce, *Second Quarter of Fiscal Year 2020 Designated HPSA Quarterly Summary*, U.S. DEPT. OF HEALTH & HUMAN SERV., (Mar. 31, 2020), <https://data.hrsa.gov/Default/GenerateHPSAQuarterlyReport>.

Third, § 1834(m) only allows services to be reimbursed to the practitioner if the services are provided to a Medicare beneficiary at an “originating site.”⁶⁰ The Act requires that a patient be physically present in a qualified facility, which must be located in either (1) a county outside a Metropolitan Statistical Area, or (2) a rural Health Professional Shortage Area.⁶¹ So, this third requirement installs two additional barriers to telemedicine utilization: it prohibits individuals from receiving telemedicine care from their own homes, instead requiring them to go to a local health care facility⁶² which serves as a bridge to the distant provider, and it also creates an additional geographic restriction by prohibiting facilities located in more developed areas from serving as an originating site.

CMS has recently attempted to expand access to telemedicine services despite the confines of § 1834(m). The primary method through which it has done so is by skirting the § 1834(m) regulations through the codification of “Communication Technology-Based Services” and other similar services that fit outside of CMS’s interpretation of the term “telemedicine.”⁶³ These codes allow Medicare to reimburse providers for “telehealth-like” care delivery.⁶⁴ CMS continues to create new codes each year to reimburse for new forms of telemedicine or correct other deficiencies in preexisting codes.⁶⁵

60. 3 HEALTH L. PRAC. GUIDE § 46:26, Westlaw (database updated Dec. 2020).

61. *Telehealth Services*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/TelehealthSrvcsfctsht.pdf>.

62. Social Security Act, 42 U.S.C. § 1834(m)(4)(C)(ii), 42 U.S.C. § 1395(m) (2015) (listing sites that qualify as an origination site include a hospital, a physician’s office, and a Federally Qualified Health Center).

63. *Medicare Expands Payment for Telehealth and Remote Patient Monitoring Services*, MTELEHEALTH, <https://mtelehealth.com/medicare-expands-payment-for-telehealth-and-remote-patient-monitoring-services/> (last visited Mar. 6, 2021).

64. *Id.*

65. *See Healthcare Common Procedure Coding System (CHPCS) Level II Coding Procedures*, CTRS. FOR MEDICARE & MEDICAID SERVS (Sept. 16, 2020), <https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/Downloads/2018-11-30-HCPCS-Level2-Coding-Procedure.pdf> (describing CMS’s process for approving new billing codes).

b. Value-Based Payment Models in Medicare

Finally, there have been recent advancements within CMS to create alternative reimbursement systems for Medicare grounded in value-based care. These include the Quality Payment Program and the CMS Innovation Center. While an in-depth discussion of the particularities of different value-based reimbursement models exceeds the goals of this note, a high-level understanding of how these models differ from traditional fee-for-service is important in understanding how telemedicine delivery would be accounted for in alternative payment systems.

The Quality Payment Program went into effect in 2017 and outlines two payment mechanisms for eligible providers: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Models (APMs).⁶⁶ These payment tracks aim to reward clinicians for quality of care given to Medicare patients without increasing health care costs.⁶⁷ MIPS consolidates various data reporting programs previously utilized by CMS⁶⁸ in order to generate a score for providers based on several performance metrics.⁶⁹ The score that MIPS generates for each provider does not directly provide reimbursement to providers; rather, it adjusts the payment that providers ordinarily receive under a fee-for-service model.⁷⁰ About 90% of clinicians eligible

66. King, *supra* note 33, at 297; *Value-Based Reimbursement and Quality Initiatives*, PRACTICE FUSION, <https://www.practicefusion.com/quality-payment-program/> (last visited Apr. 17, 2020).

67. MACRA, *Value-Based Care and the Quality Payment Program*, NTHRIVE, <https://www.nthrive.com/blog/value-based-care-macra-qpp> (last updated Apr. 12, 2017).

68. Among the former programs consolidated within MIPS are the Medicare Electronic Health Records Incentive Program for Eligible Clinicians, the Physician Quality Reporting System, and the Value-Based Payment Modifier. *MIPS Overview*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://qpp.cms.gov/mips/overview> (last visited Apr. 17, 2020).

69. The four MIPS performance categories are (1) “Quality,” which allows providers to “pick the six measures of performance that best fit [their] practice,” (2) “Promoting Interoperability,” which scores providers based on their patient engagement and electronic exchange of health information with other clinicians in order to facilitate less fragmented system-wide care, (3) “Improvement Activities,” which “includes an inventory of activities that assess how [providers] improve [their] care processes, enhance patient engagement in care, and increase access to care,” and (4) “Cost,” which “uses cost measures to gauge the total cost of care during the year or during a hospital stay.” *Id.*

70. *Id.*

for the Quality Payment Program are expected to participate in MIPS.⁷¹

The second payment track, APMs, “offer[s] a [five] percent incentive payment for achieving threshold levels of payments or patients”⁷² These thresholds can be met by participating in one of several APMs promulgated by CMS, which “include[] some demonstration programs, [Accountable Care Organizations] . . . , and the initiatives by the [CMS] Center for Medicare and Medicaid Innovation Center” (Innovation Center).⁷³ The Innovation Center, which was created under § 3021 of the Patient Protection and Affordable Care Act with the charge “to test innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care,”⁷⁴ is the primary engine behind modern health care payment reform, especially in the adoption of value-based payment models.⁷⁵ The Innovation Center generates APMs that are only approved by the Secretary of Health and Human Services for implementation if the model can be expected to reduce spending without compromising quality of care—or, if it improves quality of care without increasing spending—and without reducing program benefits or eligibility.⁷⁶ Thus far, the Innovation Center

71. See *What Is MIPS (Merit-Based Incentive Payment System) in Health Care?*, NTHRIVE (Apr. 13, 2017), <https://www.nthrive.com/blog/mips-merit-based-incentive-payment-system> (“CMS estimates that about 90 percent of eligible clinicians will be in the MIPS reporting camp for 2017, including both individual providers and provider groups.”).

72. *Advanced Alternative Payment Models (APMs)*, QUALITY PAYMENT PROGRAM, <https://qpp.cms.gov/apms/advanced-apms> (last visited Apr. 17, 2020).

73. *The Difference Between MIPS and APMs*, CHECKPOINT EHR, <https://checkpointehr.com/difference-between-mips-and-apms/> (last visited March 5, 2021).

74. Patient Protection and Affordable Care Act § 1115A, 42 U.S.C. § 1315a (2018). The Innovation Center’s influence was strengthened by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which introduced financial incentives for providers to participate in value-based payment programs. Medicare Access and CHIP Reauthorization Act of 2015, 42 U.S.C. § 1395w-4(p) (2018).

75. See “*What is CMMI?*” and 11 other FAQs about the CMS Innovation Center, KAISER FAMILY FOUND. (Feb. 27, 2018), <https://www.kff.org/medicare/fact-sheet/what-is-cmmi-and-11-other-faqs-about-the-cms-innovation-center/>; see also Jeff Micklos et al., *The Center for Medicare and Medicaid Innovation Can Be A Powerful Force to Accelerate Change, But Not Without Key Reforms*, HEALTH AFFAIRS (Feb. 12, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200204.111760/full>.

76. Micklos et al., *supra* note 75.

has announced more than forty reimbursement payment and service delivery models.⁷⁷ However, such initiatives are trial-only, and the Innovation Center has yet to realize a full-scale model that has been utilized by more than a sliver of health care providers.⁷⁸

Because these value-based payment models reward providers based on patient outcomes rather than quantity of services delivered, codes that recognize telehealth care delivery are not needed. Instead, providers that leverage telemedicine technologies to deliver care in a more efficient manner will generate higher levels of revenue based on the reduction of more costly, in-person resources and the improvement of long-term health outcomes.⁷⁹

c. Temporary Changes in Medicare Telemedicine Reimbursement due to COVID-19

In order to facilitate social distancing necessities caused by COVID-19, CMS made temporary changes to its telemedicine reimbursement in 2020.⁸⁰ For example, CMS temporarily removed the geographic restrictions included in § 1834(m), allowing providers to get reimbursed for care given to Medicare beneficiaries living in any area, including cities.⁸¹ Additionally, it included a patient's home as a possible "originating site" under § 1834(m),⁸² removing the need for patients to visit a separate facility to meet virtually with a practitioner. Last, CMS began allowing providers to get reimbursed for some services delivered only by phone, which diverges from its usual requirement for synchronous video

77. *Id.*

78. *See id.*

79. *See Report: Telehealth Adoption 'May Help Drive Transition' to Value-Based Care*, CARE INNOVATIONS, <https://news.careinnovations.com/blog/telehealth-adoption-may-transition-to-value-based-healthcare> (last visited Feb. 8, 2021).

80. CMS's ability to enact these temporary changes was authorized by the Coronavirus Preparedness and Response Supplemental Appropriations Act and the Family First Coronavirus Response Act. *See* Coronavirus Preparedness and Response Supplemental Appropriations Act, Pub. L. No. 116-123, 134 Stat. 155 (2020); Families First Coronavirus Response Act, Pub. L. N. 116-127, § 6010, 134 Stat. 210 (2020).

81. *See* Coronavirus Preparedness and Response Supplemental Appropriations Act, *supra* note 80, at § 102; *see also* Cntrs. for Medicare & Medicaid Serv., *supra* note 36.

82. *See* Coronavirus Preparedness and Response Supplemental Appropriations Act, *supra* note 80, at § 102.

conference.⁸³ These changes affect all services, regardless of diagnosis; patients need not be seeking COVID-19 related services for providers to utilize this expanded reimbursement.⁸⁴

CMS's temporary changes were part of a broader scheme by the federal government to encourage people to seek health care from the safety of their homes. Other changes made at the federal level include the loosening of HIPAA enforcement for telemedicine (allowing for greater utilization of services like Facetime or Skype for telehealth purposes),⁸⁵ increased access to e-prescription of controlled substances,⁸⁶ and CMS's waiving of additional licensure requirements for providers practicing across state lines.⁸⁷ Importantly, the federal government also established new grants to fund the telecommunication services and device needs of providers serving medically underserved areas,⁸⁸ allowing those providers greater latitude to implement

83. *Trump Administration Makes Sweeping Regulatory Changes to Help U.S. Healthcare System Address COVID-19 Patient Surge*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 30, 2020), <https://www.cms.gov/newsroom/press-releases/trump-administration-makes-sweeping-regulatory-changes-help-us-healthcare-system-address-covid-19>.

84. See Gabriela Weigel et al., *Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond*, KAISER FAMILY FOUND. (May 11, 2020), <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>.

85. See *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency*, U.S. DEPT. OF HEALTH & HUM. SERVS. (Mar. 17, 2020), <https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html>; Weigel et al., *supra* note 84. But see National Consortium of Telehealth Resource Centers, *NCTRC Webinar - Telehealth Policy Updates in 2020*, YOUTUBE (Jan. 17, 2020), <https://youtu.be/fWIfNgbyV88> (noting that HIPAA exists to protect patient protected health information, and exchanging that information over non-HIPAA compliant platforms risks that information being accessed, shared, or sold by those platforms).

86. See Diversion Control Division, *How to Prescribe Controlled Substances to Patients During the COVID-19 Public Health Emergency*, DRUG ENFORCEMENT ADMIN., [https://www.deadiversion.usdoj.gov/GDP/\(DEA-DC-023\)\(DEA075\)Decision_Tree_\(Final\)_33120_2007.pdf](https://www.deadiversion.usdoj.gov/GDP/(DEA-DC-023)(DEA075)Decision_Tree_(Final)_33120_2007.pdf).

87. Providers must still be licensed in their home state. See CTRS. FOR MEDICARE & MEDICAID SERV., PHYSICIANS AND OTHER CLINICIANS: CMS FLEXIBILITIES TO FIGHT COVID-19 7–8 (Jan. 28, 2021), <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>.

88. See CARES Act., Pub. L. No. 116-136, §§ 3212–13 (2020).

systematic changes in care delivery that may otherwise have been financially infeasible.⁸⁹

ii. Reimbursement in Medicaid

a. Telemedicine Reimbursement

Medicaid is another public health care program that covers low-income individuals and families. Traditionally, a significant majority of individuals who were covered by Medicaid were low-income Medicare beneficiaries.⁹⁰ However, after the Medicaid expansion, passed as part of the Affordable Care Act, access to Medicaid grew substantially.⁹¹ Now, in all but 12 states,⁹² almost any non-Medicare-eligible individual with an income under 138% of the federal poverty limit (FPL) is eligible for Medicaid.⁹³ Individuals who are eligible for Medicare may enroll in Medicaid to cover either their Medicare premiums or the enrollee's portion of the cost-sharing so long as they are under 135% FPL (though full benefits are received only if under 100% FPL).⁹⁴

Besides the populations eligible for these two programs, as well as the extent of their coverage, there is another significant

89. *Cf.* Kyle Samani, *Why are Telemedicine Systems so Expensive?*, HEALTHCARE IT TODAY (Jul. 17, 2014), <https://www.healthcareittoday.com/2014/07/17/why-are-telemedicine-systems-so-expensive/> (listing challenges health systems face when transitioning their business models to utilize telemedicine in routine care).

90. *See* Robin Rudowitz et al. *10 Things to Know about Medicaid: Setting the Facts Straight*, KAISER FAMILY FOUND. (Mar. 6, 2019), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/> (“Under the original 1965 Medicaid law, Medicaid eligibility was tied to cash assistance . . . for . . . the poor aged, blind, and people with disabilities.”).

91. *See Id.*

92. *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAMILY FOUND. (Feb. 12, 2021), <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>.

93. *See Eligibility*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/eligibility/index.html>; *Medicaid Expansion & What it Means for You*, HEALTHCARE.GOV, <https://www.healthcare.gov/medicaid-chip/medicaid-expansion-and-you/> (“In states that have expanded Medicaid coverage: You can qualify based on your income alone. If your household income is below 133% of the federal poverty level, you qualify. []Because of the way this is calculated, it turns out to be 138% of the federal poverty level. A few states use a different income limit.[]”).

94. *See Seniors & Medicare and Medicaid Enrollees*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/eligibility/medicaid-enrollees/index.html>.

difference between Medicaid and Medicare. While Medicare is governed entirely by CMS, Medicaid is state-controlled and federally approved.⁹⁵ CMS establishes certain parameters on what populations and services must be or may be covered, and states decide exactly how to implement the program.⁹⁶ Should states decide to cover populations or services that are not required or already approved by CMS, they may submit a waiver to request permission from CMS to implement the program, or else they are not eligible for federal dollars to pay for that portion of the program.⁹⁷

When it comes to telehealth, CMS allows reimbursement for limited telehealth services within Medicaid, but states ultimately choose whether to allow it and can further limit the scope of covered services.⁹⁸ While state control might encourage more innovation—a *la* “laboratories of democracy”—a variety of state-regulated issues, such as interstate care, HIPAA violations, and anti-kickback regulations add extra hurdles that states must cope with in their administration of Medicaid.⁹⁹ Despite these challenges, no uniform code for telehealth has been developed, nor has there been any federal promulgation of guidelines.¹⁰⁰ As

95. See Kelly Montgomery, *Types and Purposes of Medicaid Waivers: How States Use Medicaid Waivers to Customize Their Medicaid Programs*, VERYWELL HEALTH, <https://www.verywellhealth.com/medical-waivers-what-are-medicaid-waivers-1738846> (last updated Mar. 12, 2020); *How is Medicare Funded?*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicare.gov/about-us/how-is-medicare-funded#:~:text=The%20Centers%20for%20Medicare%20%26%20Medicaid,covered%20over%2058%20million%20people> (“The Centers for Medicare & Medicaid Services (CMS) is the federal agency that runs the Medicare Program. CMS is a branch of the Department of Health and Human Services (HHS). CMS also monitors Medicaid programs offered by each state.”).

96. See Laura Snyder & Robin Rudowitz, *Medicaid Financing: How Does it Work and What are the Implications?*, KAISER FAMILY FOUND. (May 20, 2015), <https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/>.

97. See *id.*

98. See *State Telehealth Policies*, NAT’L CONFERENCE OF STATE LEGISLATURES, <https://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx> (last updated Jan. 13, 2021).

99. See Jayme R. Matchinski, *Telehealth and Telemedicine: Surveying the Regulatory Landscape*, WESTLAW J. HEALTH L. (Oct. 2018), at 1, https://www.greensfelder.com/media/publication/333_Matchinski_telehealth-telemedicine_Oct2018.pdf.

100. *Id.* (“Currently, there are no uniform telehealth regulations other than the Medicare and Medicaid coverage guidelines and regulations, and no federal telehealth statutes or regulations have been promulgated.”).

a result of this absence of a uniform approach, a complex web of state-by-state telehealth regulations has emerged.

Despite this lack of uniformity, some common approaches do exist. For example, almost half of states have “parity laws,” laws that require health insurers to reimburse telehealth services in a similar manner as if they were delivered in person.¹⁰¹ The half of states that do not have such parity laws have little incentive to provide telehealth services, unless those equitable rates are negotiated between providers and insurers.¹⁰²

In general, reimbursement for telemedicine is broader in Medicaid than in Medicare. Nearly all Medicaid programs reimburse for some type of synchronous care—most commonly live-video appointments.¹⁰³ More advanced forms of telehealth delivery are not as widely recognized: only 11 states reimburse store-and-forward telemedicine, and 20 states reimburse for RPM.¹⁰⁴ These RPM reimbursements, however, are usually limited to specific specialty care, such as dermatology and ophthalmology.¹⁰⁵ Finally, Medicaid is not subject to § 1834(m), like Medicare, and, as such, is not beholden to its limitations. As a result, most Medicaid programs have not limited telehealth access to individuals in rural areas, allowing Medicaid beneficiaries who live in urban areas to benefit from telemedicine.¹⁰⁶ However, barriers to widespread adoption of telehealth practices still exist. For example, most states provide no reimbursement for audio (i.e., telephone) or text-only services, and over half of states

101. *Id.* (“Generally, these ‘parity’ state laws require health insurers to cover and provide reimbursement for services provided via telehealth in a comparable manner to how the payer would for the same services provided in person.”). *But see* Susan Ladika, *Telehealth Dials Up Discussion About Payment to Providers*, MANAGED CARE, June 2016, at 19, <https://www.managedcaremag.com/archives/2016/6/telehealth-dials-discussion-about-payment-providers> (“But payment for a telehealth visit isn’t the same as for an office visit, he says. ‘If people think this should be on the same fee schedule as a visit in the office, it really isn’t the same. The service doesn’t include some of the key elements,’ such as taking a patient’s blood pressure or listening to his heart and lungs.”).

102. Katherine W. Dandy et al., *The Case for Telemedicine: How Telehealth Solutions Can Reduce Legal Risk While Improving Patient Access and Lowering Health Care Costs*, N.Y. ST. B.J. 39 (2018), at 42.

103. *See* CTR. FOR CONNECTED HEALTH POLICY, STATE TELEHEALTH LAWS & REIMBURSEMENT POLICIES 2–3 (2018), https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf.

104. *See id.* at 3.

105. Kwong, *supra* note 22, at 18.

106. *See* CTR. FOR CONNECTED HEALTH POLICY, *supra* note 103, at 9.

require patients to receive telehealth care at an originating site outside of the patient's home.¹⁰⁷

b. Value-based payment models in Medicaid

1. Managed Care

States have increasingly expanded managed care utilization in their Medicaid programs such that it is now the most widely used payment model.¹⁰⁸ In its most common form, managed care helps Medicaid programs control spending by paying insurers a risk contract with a fixed per capita payment rate.¹⁰⁹ Costs are controlled for the state since it simply pays insurers a fixed rate for each enrollee.¹¹⁰ However, the risk therefore shifts to insurers, which experience substantial benefit if the care of enrollees falls below the risk contract but experience severe detriment if a patient's care far exceeds the risk contract.¹¹¹ For that reason, the insurer "manages" enrollees' care by educating them and improving health and insurance literacy, utilizing information systems to track group outcomes with quality measures, and providing financial incentives and other forms of coordination to encourage providers to reduce needless care.¹¹² Managed care

107. CTR. FOR CONNECTED HEALTH POLICY, STATE TELEHEALTH LAWS & REIMBURSEMENT POLICIES 9 (2020), https://www.cchpca.org/sites/default/files/2020-05/CCHP_%2050_STATE_REPORT_SPRING_2020_FINAL.pdf.

108. See CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE ENROLLMENT AND PROGRAM CHARACTERISTICS, 2018, at 10 (2020), <https://www.medicaid.gov/medicaid/managed-care/downloads/2018-medicaid-managed-care-enrollment-report.pdf>.

109. See *Provider Payment and Delivery Systems*, MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, <https://www.macpac.gov/medicaid-101/provider-payment-and-delivery-systems/>.

110. See Elizabeth Hinton et al., *10 Things to Know about Medicaid Managed Care*, KAISER FAMILY FOUND. (Oct. 29, 2020), <https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-managed-care/>.

111. Compare MICHAEL SPARER, ROBERT WOOD JOHNSON FOUND., MEDICAID MANAGED CARE: COSTS, ACCESS, AND QUALITY OF CARE (Sept. 2012), <https://www.rwjf.org/en/library/research/2012/09/medicaid-managed-care.html>, with Daniel Franco Montoya et al., *Medicaid Managed Care's Effects on Costs, Access, and Quality: An Update*, 41 ANN. REV. OF PUB. HEALTH 537, 538 (2020).

112. SEE MEDICAID AND CHIP PAYMENT AND ACCESS COMM'N, *supra* note 109. But see Jeff C. Goldsmith et al., *Medicaid Managed Care: Lots of Unanswered Questions (Part 2)*, HEALTH AFFAIRS (May 4, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180430.510086/full/> (finding no peer reviewed research showing managed care reduces overall costs or improves outcomes).

organizations cover nearly all services covered by the state's fee-for-service program and may cover additional services not covered by fee-for-service.¹¹³

Over the long term, the goal of managed care is to improve provider and patient behavior such that excess care is removed, unnecessary and expensive patient behavior like utilization of the emergency room for primary care is eliminated, and savings are achieved.¹¹⁴ However, the evidence is unclear as to whether the growth of managed care has achieved the anticipated savings¹¹⁵ or whether outcomes have been improved.¹¹⁶ Some even suggest that managed care creates incentives to undertreat patients in order to achieve cost savings.¹¹⁷ Additionally, managed care does not fundamentally change the way that providers get reimbursed—contracts with providers remain grounded in fee-for-service payment rates negotiated by the managed care organization.¹¹⁸

113. See Goldsmith et al., *supra* note 112 (describing “in lieu of” policies used by managed care organizations).

114. See *Managed Care*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.medicaid.gov/medicaid/managed-care/index.html>; Christine Vestal, *Managed Care Explained: Why a Medicaid Innovation is Spreading*, PEW CHARITABLE TR. (May 31, 2011), <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2011/05/31/managed-care-explained-why-a-medicaid-innovation-is-spreading> (“The MCO’s goal is to keep patients as healthy as possible by encouraging them to get regular check-ups and inoculations while eliminating unnecessary procedures.”).

115. *Compare States Could Save Money by Expanding Medicaid Managed Care*, HEALTHLEADERS MEDIA (May 20, 2009), <https://www.healthleadersmedia.com/finance/states-could-save-money-expanding-medicaid-managed-care> (finding that savings between 0.5% and 20% can be achieved through utilization of managed care), with Mark Duggan & Tamara Hayford, *Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates* (Nat’l Bureau of Econ. Research, Working Paper No. 17236, 2011), https://www-nber-org.ezp3.lib.umn.edu/system/files/working_papers/w17236/w17236.pdf (finding that shifts to managed care may have resulted in greater Medicaid expenditures).

116. See Robert Miller & Harold Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 HEALTH AFFAIRS 5 (1997).

117. Ellen Green, *Payment Systems in the Healthcare Industry: An Experimental Study of Physician Incentives*, 106 J. ECON. BEHAV. & ORG. 367 (2014).

118. *Managed Care’s Effect on Outcomes*, MEDICAID & CHIP PAYMENT & ACCESS COMM’N, <https://www.macpac.gov/subtopic/managed-cares-effect-on-outcomes/> (last visited Mar. 18, 2021).

2. Value based payment arrangements

Value-based payment methodologies are rapidly increasing in their popularity, both in fee-for-service and managed care Medicaid programs, but such methodologies remain in their infancy and are most commonly used in trials.¹¹⁹ These programs include Delivery System Reform Incentive Payments programs, Pay for Performance programs, Shared Savings programs, and Episode of Care models.¹²⁰ Growth in this area has been stifled by the wide variety of payment methodologies utilized, as well as the flexibility, or lack thereof, that states allow payments to be customized to the needs of individual providers.¹²¹ This variety has precluded convincing evidence of which programs work best, though most experts agree value-based payment would improve efficiency and outcomes in care, a transition to such models would require significant care delivery reform.¹²²

c. Temporary Changes to Medicaid Telemedicine Reimbursement Due to COVID-19

While Medicaid benefits are shaped by each state, CMS published several guidance documents during 2020 to encourage states to utilize “broad flexibility” in their reimbursement for Medicaid services delivered via telehealth.¹²³ This guidance,

119. Shannon Muchmore, *Nearly All States Using Value-Based Payment Models*, HEALTHCARE DIVE (Apr. 16, 2019), <https://www.healthcaredive.com/news/nearly-all-states-using-value-based-payment-models/552802/> (explaining that while 48 states now use some form of value-based payment models, only a fraction of payments come from risk-based contracts).

120. *See generally* AM. MED. ASS’N, EVALUATING MEDICAID VALUE-BASED CARE MODELS (2019), <https://www.ama-assn.org/system/files/2019-04/medicaid-value-based-care-models.pdf>.

121. Michael Brady, *States Testing Value-Based Payments in Medicaid Managed Care*, MODERN HEALTHCARE (Feb. 27, 2020, 4:43 PM) <https://www.modernhealthcare.com/medicaid/states-testing-value-based-payments-medicoid-managed-care>.

122. *Id.*; *see also* DEBRA J. LIPSON ET AL., CTRS. FOR MEDICARE & MEDICAID SERVS., ACCELERATING THE ADOPTION OF VALUE-BASED PAYMENT IN MEDICAID BY LINKING DELIVERY SYSTEM REFORM TO MANAGED CARE PAYMENT, (2019), <https://www.medicoid.gov/medicaid/downloads/accel-adoption-vp-pay.pdf> (comparing a variety of value-based payment Medicaid pilot programs and presenting questions with which to evaluate their future performance).

123. *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance (CHIP) Agencies*, *supra* note 36. *See also* CTRS. FOR MEDICARE & MEDICAID SERVS., *State Medicaid & CHIP Telehealth Toolkit*:

given “to ensure that Medicaid services are delivered in a safe and economical manner,” broadly encourages states to increase Medicaid payments to telemedicine services.¹²⁴ It even removes the requirement for federal approval to most amendments to Medicaid plan statements and managed care contracts designed to reimburse providers for telemedicine at the same rate as for in-person care.¹²⁵

Nearly all states utilized this flexibility to make changes to their Medicaid reimbursement policies.¹²⁶ For example, many states with originating site requirements began allowing the patient’s home to be used as an originating site, and most states also expanded modality restrictions to allow providers reimbursement for evaluations given over the telephone.¹²⁷ Additionally, while states have varying policies regarding whether a patient-doctor relationship can be formed via telemedicine or if it must first exist via a face-to-face encounter before telemedicine can be used,¹²⁸ some of those states that have such a requirement are waiving it for the duration of the public health emergency.¹²⁹ States have also worked to expand telemedicine in specific service areas that have traditionally lagged in utilization, such as behavior health, pediatric health, reproductive and maternal health, dentistry, speech therapy, physical therapy, and

COVID-19 Version (2020), <https://www.medicaid.gov/medicaid/benefits/downloads/medicaid-chip-telehealth-toolkit.pdf>.

124. *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children’s Health Insurance (CHIP) Agencies*, *supra* note 36.

125. *Id.*; see also Madeline Guth & Elizabeth Hinton, *State Efforts to Expand Medicaid Coverage & Access to Telehealth in Response to COVID-19*, KAISER FAMILY FOUND. (Jun. 22, 2020), <https://www.kff.org/coronavirus-covid-19/issue-brief/state-efforts-to-expand-medicaid-coverage-access-to-telehealth-in-response-to-covid-19/> (explaining that while federal approval isn’t necessary for modifications to reimbursement policies, states must still receive federal approval for use of Medicaid emergency authorities, such as 1115 waivers, 1135 waivers, and 1915 (c) waivers, which can be used to do things like removing licensing requirements for out-of-state telehealth providers and broaden telemedicine services available for home and community-based services enrollees).

126. *Quick Glance State Telehealth Actions in Response to COVID-19*, CTR. FOR CONNECTED HEALTH POLICY, (May 30, 2020, 5:00 PM), https://www.naadac.org/assets/2416/state_telehealth_actions_in_response_to_covid_overview_3292020.pdf.

127. *Id.*

128. *50-State Survey: Establishment of a Patient-Physician Relationship Via Telemedicine*, AM. MED. ASS’N (2018), <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf>.

129. CTR. FOR CONNECTED HEALTH POLICY, *supra* note 126.

occupational therapy.¹³⁰ In all, 46 states expanded telehealth coverage in some way during the 2020 public health emergency, and 38 states installed temporary payment parity for some or all telemedicine services.¹³¹ By default, these changes to state Medicaid programs will expire at the end of the public health emergency, but states may choose to continue using expanded policies.¹³²

II. ANALYSIS

A. TELEMEDICINE HAS THE POTENTIAL TO CREATE A MORE EQUITABLE, EFFECTIVE, AND AFFORDABLE HEALTH CARE SYSTEM

The growth of telemedicine technologies has fundamentally changed the way many people engage with the healthcare system, and never have those changes manifested themselves more clearly than in the era of COVID-19. A continued inclusion of telemedicine in routine care would provide substantial benefit to patients and to the health system at large, and those benefits are worth pursuing.

i. Improving Access

The U.S. Department of Health and Human Services has explicitly recognized improvements to health care access as one of its primary objectives for the next decade.¹³³ Telemedicine can play a central role in meeting that objective. The first way in which telehealth improves health care access aligns with the historical outgrowth of the technology: it allows people with barriers to seeing a doctor to receive quality care. Of course, examples of that were plenty in 2020, as the necessities of social distancing during a global pandemic prompted widespread adoption of telemedicine utilization. Yet even when Americans may move more freely, inequities in health care access are widespread, and tele-

130. Guth & Hinton, *supra* note 125.

131. Weigel et al., *supra* note 84.

132. Guth & Hinton, *supra* note 125.

133. U.S. Dep't of Health & Human Servs., *Increase the Proportion of Adults Who Get Recommended Evidence-Based Preventative Health Care*, HEALTHY PEOPLE 2030, <https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality/increase-proportion-adults-who-get-recommended-evidence-based-preventive-health-care-ahs-08> (last visited Feb. 8, 2021).

medicine can play a central role in remedying that societal shortcoming.¹³⁴ In particular, two of the populations that most benefit from telemedicine are those who use rural hospitals and patients who rely on skilled nursing and long-term care facilities.¹³⁵

While it may appear obvious that rural Americans have lower health care access than those who live in cities—after all, the largest health care systems are located in urban areas¹³⁶—the problem has been exacerbated in recent years, with nearly 100 rural hospitals closing their doors since the beginning of 2010.¹³⁷ A significant cause of these closures may be the ACA’s Medicaid Expansion, which prompted low-income, rural Americans who gained access to coverage to simultaneously seek care, receiving expensive treatment for chronic conditions that were ignored for years.¹³⁸ However, telemedicine helps stifle the repercussions of these closures, as it allows rural Americans to receive care from specialists from larger hospitals, which have the capacity to coordinate high-quality care more efficiently, allowing generalists at rural clinics to serve more day-to-day needs.¹³⁹

134. See, e.g., Rumi Chunara et al., *Telemedicine and Healthcare Disparities: A Cohort Study in a Large Healthcare System in New York City During COVID-19*, 28 J. AM. MED. INFORMATICS ASS’N 33 (2021); Tara van Veen et al., *Potential of Mobile Health Technology to Reduce Health Disparities in Underserved Communities*, 20 WESTERN J. EMERGENCY MED., 799, 799–802 (2019).

135. King, *supra* note 33, at 316.

136. See, e.g., Health Policy Institute, *Rural and Urban Health*, GEO. U., <https://hpi.georgetown.edu/rural/> (“Less than 11 percent of physicians in the U.S. practice in rural areas, yet about 20 percent of the population resides in rural areas.”).

137. Victoria Pelham, *Medicaid Overhaul Could Imperil Rural Health, Analysts Warn*, BLOOMBERG L. (May 23, 2017), <https://www.bna.com/medicaid-overhaul-imperil-n73014451402>; see also *83 Rural Hospital Closures: January 2010 - Present*, UNC CECIL G. SHEPS CTR. FOR HEALTH SERVS. RES., <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures>.

138. See CRISTINA BOCCUTI & GISELLE CASILLAS, KAISER FAMILY FOUND., AIMING FOR FEWER HOSPITAL U-TURNS: THE MEDICARE HOSPITAL READMISSION REDUCTION PROGRAM. 8–9 (2017), <http://files.kff.org/attachment/Issue-Brief-Fewer-Hospital-U-turns-The-Medicare-Hospital-Readmission-Reduction-Program> (observing that Medicare readmission rates and penalties are higher among rural hospitals, and among hospitals with higher proportions of low-income Medicare patients).

139. See Gary Capistrant, *Licensure*, AM. TELEMEDICINE ASS’N, in THE ROLE OF TELEMEDICINE IN AN EVOLVING HEALTH CARE ENVIRONMENT: WORKSHOP SUMMARY 20 (2012) (arguing that the telehealth system could be reformed and expanded to allow rural patients access to more specialized medicine, and to increase provider productivity).

Unfortunately, individuals in these rural communities also tend to have underdeveloped infrastructure and capability to support telemedicine.¹⁴⁰

As it pertains to long-term care facilities, when residents require significant medical attention, they often must be transported to a hospital, where they may be exposed to secondary infections.¹⁴¹ Additionally, health care outcomes tend to suffer when elders and other patients in long-term care have no access to assistance from a friend, advisor, or attorney at an unfamiliar hospital, resulting in a legal and bureaucratic maze of the health care system that can be overwhelming to the patient.¹⁴² Secondary infections and low comprehension of one's interactions with the health care system both lead to high rates of readmission to the hospital after discharge, particularly because patients are unable to communicate with their doctors again after they leave the hospital.¹⁴³ Higher utilization of telemedicine in long-term care clinics allows patients to stay comfortable and safe from further exposure at home, saves government health care programs substantial amounts in overnight stays, and prevents hospitals from losing money to patient readmission and the resulting Medicare penalties.¹⁴⁴

140. S. T. Liaw & J. S. Humphreys, *Rural eHealth Paradox: It's Not Just Geography!*, 14 AUSTL. J. RURAL HEALTH 3, 95–98 (2006) (“Rural areas stand to benefit most from eHealth but have the poorest infrastructure, resources, capacity and capability for successful implementation and uptake.”).

141. *HAI Data and Statistics*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 25, 2016), <https://www.cdc.gov/hai/surveillance/index.html> (“On any given day, about one in 25 hospital patients has at least one healthcare-associated infection.”).

142. *See Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents*, CTRS. FOR MEDICARE & MEDICAID SERV. (Oct. 20, 2017), <https://innovation.cms.gov/initiatives/rahnfr> (“LTC facility residents often experience potentially avoidable inpatient hospitalizations. These hospitalizations are expensive, disruptive, and disorienting for seniors and people with disabilities.”).

143. *See* Phil McNulty, *Achieving Meaningful ROI by Reducing Rehospitalizations*, MCKNIGHT'S LONG-TERM CARE NEWS (Sept. 21, 2015), <https://www.mcknights.com/marketplace/achieving-meaningful-roi-by-reducing-rehospitalizations/> (discussing the importance of increased off-site communication to reducing hospital readmissions).

144. *Id.*; Niall Brennan & Tim Engelhardt, *Data Brief: Sharp Reduction in Avoidable Hospitalizations Among Long-Term Care Facility Residents*, TELLIGEN, <https://www.telligenqinqio.com/news/data-brief-sharp-reduction-in-avoidable-hospitalizations-among-long-term-care-facility-residents/> (last visited Mar. 18, 2021).

Wider utilization of telemedicine and growth in the telehealth technology sector also has great potential to increase health care access for all patients, regardless of geographic location and individual circumstance. Even Americans who have access to various providers in their communities face structural barriers to receiving care, primary among them temporal restrictions that necessitate wait times of days to weeks to receive an appointment,¹⁴⁵ as well as the lengthy duration of triage and care in a hospital setting that requires patients to take leave from work to receive primary care.¹⁴⁶ The use of telemedicine—both to replace in-person appointments via synchronous and asynchronous communications, as well as to supplement traditional appointments through RPM tracking—would allow all patients greater flexibility to access care and remain engaged with their health.

First, greater use of telehealth could decrease the average time a patient must wait to see a doctor after scheduling an appointment. Without widespread telehealth, the average new patient must wait about 24 days to see a primary caregiver, up from 18.5 days in 2014.¹⁴⁷ Waits become even longer when one

145. Cf. Fiona MacKichan et al., *Why Do Patients Seek Primary Medical Care in Emergency Departments? An Ethnographic Exploration of Access to General Practice*, 7 *BMJ OPEN* 1, 7(2017), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5623418/> (observing that, because waiting times for routine appointments in a set of practices were 4 to 14 days, patient demand for care in more expensive settings, like walk-in clinics and emergency rooms, has massively increased).

146. See, e.g., Trisha Torrey, *Reasons Why You Spend So Long Waiting at the Doctor's Office*, VERYWELL HEALTH (Feb. 14, 2020), <https://www.verywellhealth.com/why-do-i-wait-so-long-at-the-doctors-office-2615092> (discussing perspectives on the long waiting times in primary health care); Markham Heid, *Why Doctor's Office Wait Times Are So Damn Long, According to Doctors*, MEN'S HEALTH (Oct. 19, 2017), <https://www.menshealth.com/health/a19539119/why-are-doctors-wait-times-so-long/>; Steven Petrow, *My Doctor Kept Me Waiting Forever. Can I Get Some Sort of Refund?*, WASH. POST (Jan. 20, 2018), https://www.washingtonpost.com/national/health-science/my-doctor-kept-me-waiting-forever-can-i-get-some-sort-of-refund/2018/01/19/7533793e-fbab-11e7-8f66-2df0b94bb98a_story.html; Barbara Bronson Gray, *Long Waits at the Doctor's Office Disrespect Patients*, KEVINMD.COM (May 1, 2012), <https://www.kevinmd.com/blog/2012/05/long-waits-doctors-office-disrespect-patients.html>.

147. MERRITT HAWKINS, 2017 SURVEY OF PHYSICIAN APPOINTMENT WAIT TIMES AND MEDICAID AND MEDICARE ACCEPTANCE RATES (2017) <https://www.merrithawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf>.

looks outside of the nation's largest cities; even in mid-sized metropolitan areas, the average wait time to see a family medicine physician is 54.3 days.¹⁴⁸ While patients with a patient-doctor relationship already formed typically need not wait so long to meet with their physicians, wait times can still be as long as two weeks, resulting higher utilization of urgent care settings for primary care purposes.¹⁴⁹

Another way in which telemedicine increases health care access is by reducing the amount of time it takes to see a doctor on the day of a patient's appointment. Health care systems often utilize a triage-based method of care delivery, where patients have a conversation with one or several preliminary caregivers and then endure lengthy waits as those initial professionals decide what specialist or other kind of caregiver the patient ought to see.¹⁵⁰ Such a process, though convenient for health systems, often results in long, seemingly unnecessary waits for the patient.¹⁵¹ By using telemedicine, patients can deliver much of this information in advance of an appointment, and a primary caregiver can refer that patient to the appropriate specialist, bypassing this triage stage and the unnecessary time in a waiting room that accompanies it.¹⁵² This time savings is significant: a family visit to the clinic takes an average of 121 minutes,¹⁵³ compared to less than 15 minutes for a telemedicine visit.¹⁵⁴

Finally, advancing technology provides limitless opportunity for patients to better engage with their care, monitor chronic conditions, and develop healthier lifestyles. Wearable technology and other basic RPM devices are available direct-to-

148. *Id.*

149. MacKichan et al., *supra* note 145.

150. See, e.g., Frances Bunn, Geraldine Byrne & Sally Kendall, *The Effects of Telephone Consultation and Triage on Healthcare Use and Patient Satisfaction: A Systematic Review*, 55 BRITISH J. GEN. PRAC. 521, 956 (2005) (explaining the telephone consultation and triage system).

151. *Id.*

152. See ELTON & O'RIORDAN, *supra* note 32 (advocating for a model of care oriented on convenience to the patient).

153. Jake Miller, *Paying for Health Care with Time*, HARV. GAZETTE (Oct. 5, 2015), <https://news.harvard.edu/gazette/story/2015/10/paying-for-health-care-with-time/>.

154. AMERICAN WELL, TELEHEALTH INDEX: 2017 CONSUMER SURVEY (2017), http://go.americanwell.com/rs/335-QLG-882/images/American_Well_Telehealth_Index_2017_Consumer_Survey.pdf.

consumer, and practitioners could utilize that technology to improve health care outcomes for their patients.¹⁵⁵ Private payers are already leveraging this trend, providing a model to apply to public program beneficiaries in the future.

For example, in 2019, Fitbit Health Solutions launched Fitbit Care, a telehealth platform aimed at conveniently providing doctors health care data from their patients to improve health care outcomes.¹⁵⁶ Using a Fitbit device, participants can track their physical activity, heart rate, and other biometrics.¹⁵⁷ Then, the Fitbit device transmits data to care teams¹⁵⁸ who use in-app texts and video conferencing to deliver “personalized digital interventions.”¹⁵⁹ Through biometric monitoring, Fitbit Care can promote behavioral interventions for health issues like tobacco cessation and weight management; deliver care for chronic conditions like diabetes, hypertension, and depression; and monitor more complex conditions like chronic pulmonary obstructive disease or congestive heart failure.¹⁶⁰

Health systems can increasingly utilize modern technology like Fitbits and Apple Watches¹⁶¹ to transform the way in which patients can access care.¹⁶² The ubiquitous nature of this kind of

155. See discussion *supra* Part I.A.ii.b.

156. Eric Wicklund, *Fitbit Launches a Connected Health Platform for mHealth Coaching*, MHEALTH INTELLIGENCE (Sept. 19, 2018) <https://mhealthintelligence.com/news/fitbit-launches-a-connected-health-platform-for-mhealth-coaching>; see also *Fitbit Launches Fitbit Care, a Powerful New Enterprise Health Platform for Wellness and Prevention and Disease Management*, FITBIT INC. (2018) <https://investor.fitbit.com/press/press-releases/press-release-details/2018/Fitbit-Launches-Fitbit-Care-A-Powerful-New-Enterprise-Health-Platform-for-Wellness-and-Prevention-and-Disease-Management/default.aspx> [hereinafter, *Fitbit Launches Fitbit Care*] (Fitbit Care partners with health plans available through employers to give access to this telehealth platform to employees; for example, Fitbit Care is the “preferred coaching solution” for the over 5 million members enrolled in Humana Inc. health insurance plans).

157. *Fitbit Launches Fitbit Care*, *supra* note 156.

158. Fitbit calls their care teams “health coaches.” *Id.*

159. *Id.*

160. *Id.*

161. *Apple Watch. Helping Your Patients Identify Early Warning Signs*, APPLE, <https://www.apple.com/healthcare/apple-watch/> (last visited Mar. 19, 2021).

162. Cf. Julian Mitchell, *This Startup Is Leading a Digital Health Revolution, Cutting Premiums and Improving Results*, FORBES (Jul. 10, 2016, 7:48 PM), <https://www.forbes.com/sites/julianmitchell/2016/07/10/this-startup-is->

technology means that health care access could be radically expanded without significant changes in consumer infrastructure.¹⁶³ This provides an opportunity for providers to utilize telemedicine as a central part of their practice—not only in post-discharge treatment and chronic condition management, but also in preventative care, managing health issues like weight, high blood pressure, and tobacco cessation before chronic conditions develop. Such advances would be especially beneficial for Medicare and Medicaid enrollees, who have a higher rate of chronic conditions than the general population.¹⁶⁴

ii. Improving outcomes

Telemedicine provides an overall benefit to health care outcomes. For example, one study found that nearly 81% of all hospital visits are related to a chronic illness,¹⁶⁵ which around one in two American adults have.¹⁶⁶ Telehealth allows doctors to reg-

leading-a-digital-health-revolution-cutting-premiums-and-improving-results/#241bcfde62f5 (noting that the digital preventative medicine industry, an \$8 billion industry, is at the crux of integrated health care solutions).

163. *But see* Sadia Anwar & Ramjee Prasad, *Framework for Future Telemedicine Planning and Infrastructure Using 5G Technology*, 100 WIRELESS PERS. COMM. 193 (2018) (indicating that a reliable 5G network will help maximize telemedicine's potential); Ameet Doshi et al., *Keep Calm and Log on: Telemedicine for COVID-19 Pandemic Response*, 15 J. Hosp. Med. 302 (2020) (describing the changes to hospital infrastructure required for large-scale telemedicine care during COVID-19).

164. John Chapel et al., *Prevalence and Medical Costs of Chronic Diseases Among Adult Medicaid Beneficiaries*, 53 AM. J. PREV. MED. 143, 144 (2018); *The Role of Medicaid for Adults with Chronic Illnesses*, KAISER FAMILY FOUND. (Nov. 2012), <https://www.kff.org/wp-content/uploads/2013/01/8383.pdf>; *see also* Marietou H. Ouayogode et al., *Association Between Care Management and Outcomes Among Patients with Complex Needs in Medicare Accountable Care Organizations*, 2 JAMA NETWORK OPEN 1,1 (2019), (“People with complex needs account of a disproportionate amount of Medicare spending . . .”).

165. *The Growing Crisis of Chronic Disease in the United States*, PARTNERSHIP TO FIGHT CHRONIC DISEASE, https://www.fightchronicdisease.org/sites/default/files/docs/GrowingCrisisofChronicDiseaseintheUSfactsheet_81009.pdf (last visited Mar. 5, 2021).

166. Peter Boersma et al., *Prevalence of Multiple Chronic Conditions Among US Adults, 2018*, 17 PREVENTING CHRONIC DISEASE PUB. HEALTH RES., PRAC. & POL., (2020), at 1 (finding that 51.1% of individuals enrolled in public health care programs report having at least one chronic condition, compared to 41.4% of individuals enrolled in private coverage and 33.2% of individuals who are uninsured).

ularly receive patient updates such that problems may be detected earlier.¹⁶⁷ Basic teleconference technology allows for far more touchpoints between practitioners and patients, since the reduction in appointment durations also frees up the practitioner's time, allowing her to consult with more patients on a given day.¹⁶⁸ This improved communication and monitoring improves the practitioner's ability to better tailor care to a patient's individualized circumstances and make whatever changes are necessary as the patient's condition develops. If utilizing RPM, any abnormal change in a patient's daily biometrics, such as her blood pressure, blood sugar, pulse, oxygen saturation, etc., can be flagged either by a reviewing professional or by AI, and a health care professional can contact the patient to prescribe a drug, conduct further evaluation, or otherwise change the patient's care plan.¹⁶⁹

Health outcomes can also be improved when telemedicine causes the patient to have greater involvement in her own care. Biometric monitors in RPM technologies can alert patients of the necessity to make behavioral changes, whether it be to take more steps, elevate one's legs to reduce swelling, or increase one's blood sugar.¹⁷⁰ The patient's involvement in her own care particularly improves health care outcomes in chronic condition management.¹⁷¹ The widespread empowerment of patients to feel in

167. Kim A. Schwartz & Bonnie Britton, *Use of Telehealth to Improve Chronic Disease Management*, N.C. MED. J. 216, 216 (2011) ("Remote patient monitoring that tracks vital signs of patients with chronic diseases is offering more-frequent contact between the patient and primary care provider, providing earlier detection of potential problems, and allowing real-time alerts, resulting in a proactive, affordable option for best-practice health care.").

168. See Carrie Chitsey, *How Does Telemedicine Improve Quality of Care?*, ONETOUCH TELEHEALTH (Jun. 4, 2020), <https://onetouchtelehealth.com/podcasts/how-does-telemedicine-improve-quality-of-care/> (noting that the average telehealth appointment lasts only 4 to 7 minutes); AMERICAN WELL, *supra* note 154 at 3 (finding that the average telehealth appointment takes less than fifteen minutes).

169. Lee, *supra* note 14, at 121.

170. Maryam Alvandi, *Telemedicine and Its Role in Revolutionizing Healthcare Delivery*, 5 AM. J. ACCOUNTABLE CARE 1, 2 (2017); see also Mona Boaz et al., *An Automated Telemedicine System Improves Patient-Reported Well-Being*, 11 DIABETES TECH. & THERAPEUTICS 181, 186 (2009) (noting that diabetic telemedicine patients experience a greater sense of control over their condition, along with highly reduced occurrences of hypoglycemic and hyperglycemic episodes).

171. See *Promote Patient Involvement and Self-Management in Treatment Decisions and Planning*, INSTITUTE FOR HEALTHCARE IMPROVEMENT,

control of their own care, combined with popular confidence in the health care system and one's ability to access her own doctor,¹⁷² can promote patient trust and improve compliance with prescribed health care plans.¹⁷³

iii. Cutting costs

Telemedicine has the potential to improve health care costs. This overlaps with improved access and improved health outcomes. The triage phase of health care delivery costs providers resources, since each patient is passed between and evaluated by several caregivers before arriving at the provider most suited to help.¹⁷⁴ Additionally, as telemedicine is implemented into preventative care and chronic conditions become better managed, long-term costs could drastically reduce.¹⁷⁵ Some studies show that even among highly sick patients, telemedicine can be used reduce overall costs and allow providers to administer better quality care to a greater amount of patients without an increase in non-telemedicine resources.¹⁷⁶ Despite this substantial poten-

<http://www.ihl.org/resources/Pages/Changes/PromotePatientInvolvementandSelfManagementinTreatmentDecisionsandPlanning.aspx> ("Patients with chronic conditions, including HIV, can be empowered to partner with providers in making decisions regarding their own health care.")

172. Cf. Amy Wheeler, *Telemedicine Is Making Our Patient-Doctor Relationships More Human. And That's a Good Thing*, KEVINMD (Jun. 1, 2020), <https://www.kevinmd.com/blog/2020/06/telemedicine-is-making-our-patient-doctor-relationships-more-human-and-thats-a-good-thing.html> (suggesting that synchronous telemedicine improves the patient-doctor relationship by breaking down the professional relationship constructed in the hospital setting and allowing both individuals to better understand who the other person is and where they are coming from).

173. Cf. Vanessa B. Sheppard et al., *Providing Health Care to Low-Income Women: A Matter of Trust*, 21 FAM. PRAC. 5, 484–91 (2004) (finding that women who lacked trust in their providers had greater levels of noncompliance, and that greater contact and improved communication with physicians positively correlated with greater levels of trust).

174. See discussion, *supra* Part II.A.i.

175. "An ounce of prevention is worth a pound of cure" is a common adage in health care, though its veracity has come under question. See, e.g., Aaron E. Carroll, *Preventative Care Saves Money? Sorry, It's Too Good to Be True*, N.Y. TIMES (Jan. 29, 2018), <https://www.nytimes.com/2018/01/29/upshot/preventive-health-care-costs.html> (refuting adage that preventative care saves money, but arguing that, even if savings have not yet been proven, improved quality of life and more manageable conditions are worth paying for).

176. See generally Centaine Snoswell et al., *Determining if Telehealth can Reduce Health System Costs: Scoping Review*, 22 J. MED. INTERNET RES. 10

tial for cost-savings, the absence of quality data measuring telemedicine spending and outcomes over the long term creates uncertainty as to the amount of savings possible.¹⁷⁷ That lack of certainty noted, some scholars are far more optimistic: one study estimated that even basic, synchronous telemedicine reduces spending by \$88 per episode,¹⁷⁸ while another found estimated savings range from \$19 to \$121 per patient visit.¹⁷⁹ At a provider level, the reduction in staffing needs for small, rural hospitals (which could leverage the specialized capabilities of health systems in different communities) could result in annual cost savings of over \$100,000.¹⁸⁰ Some estimate that telemedicine could save the US health care system a total of \$4.28 billion per year.¹⁸¹

(2020) (“The expert focus group identified 4 areas of potential savings from telehealth: productivity gains, reductions in secondary care, alternate funding models, and telementoring.”).

177. See, e.g., Hema Mistry, *Systematic Review of Studies of the Cost-Effectiveness of Telemedicine and Telecare. Changes in the Economic Evidence over Twenty Years*, 21 J. TELEMEDICINE & TELE CARE 1, 3 (2011) (indicating that general conclusions about the cost-effectiveness of telemedicine cannot be made because pilot services are unlikely to reflect true costs and benefits when telehealth technology becomes more routinely utilized); but see Isabel de la Torre-Díez et al., *Cost-Utility and Cost-Effectiveness Studies of Telemedicine, Electronic, and Mobile Health Systems in the Literature: A Systematic Review*, 21 TELEMEDICINE & E-HEALTH 81, 81 (2015) (concluding after a systematic review that some, but not all, studies demonstrate cost-savings in telemedicine utilization).

178. Patrick T. Courneya et al., *HealthPartners’ Online Clinic for Simple Conditions Delivers Savings of \$88 per Episode and High Patient Approval*, 32 HEALTH AFF., 385, 385 (2013) (“HealthPartners in Minnesota launched an online clinic called virtuwel in late 2010. After more than 40,000 cases, we report an average \$88 lower cost per episode compared with care received in traditional settings . . .”).

179. Garrison Nord et al., *On-Demand Synchronous Audio Video Telemedicine Visits Are Cost Effective*, 37 AM. J. EMERGENCY MED. 890, 892 (2019).

180. Healthcare Value Hub, *Telemedicine: Decreasing Barriers and Increasing Access to Healthcare*, ALTARUM (Nov. 2017), <https://www.healthcarevaluehub.org/advocate-resources/publications/telemedicine-decreasing-barriers-and-increasing-access-healthcare> (“Using rural specialists’ salaries from the Physician Compensation and Production Survey, the estimated annual cost savings was \$101,600.”).

181. *Telehealth: Connecting Consumers to Care Everywhere*, AM.’S HEALTH INS. PLANS (March 2019), https://www.ahip.org/wp-content/uploads/IB_Telehealth-031219.pdf.

iv. Medicaid and Medicare Populations Stand to Benefit Most From Telemedicine

The ubiquitous sorts of technology that may have the most potential to improve public health—for example, Fitbits and Apple Watches—if associated with a health plan at all, are likely to be associated with a private payer. It stands to reason that private payers, due to business models grounded in innovation and cost-savings, might be quicker to integrate modern technology into their health care reimbursement than public payers. Private insurers have commonly attempted to achieve many of the same benefits that telehealth offers through consumer incentives—for example, by reducing monthly premiums for individuals who meet certain thresholds for daily steps or for monthly gym visits.¹⁸²

Until recently, private insurers have largely limited telehealth to the synchronous modality.¹⁸³ However, private insurers appear increasingly willing to reimburse for telemedicine delivery as such technology becomes more common and as external factors, such as public attention to the increasing costs of health care, motivate them to find innovative solutions.¹⁸⁴ It seems likely that such consumer demand for telemedicine coverage will increase after the COVID-19 pandemic. Rapid adoption of telemedicine for individuals enrolled in private, employer-sponsored

182. See generally *Hidden Health Insurance Benefits You May Have*, CBS NEWS, (Feb. 22, 2011, 11:42 AM) <https://www.cbsnews.com/news/hidden-health-insurance-benefits-you-may-have/>.

183. See, e.g., *Services on Telemedicine Platforms*, HORIZON BLUE CROSS BLUE SHIELD N.J., (May 20, 2019) <https://www.horizonblue.com/providers/policies-procedures/policies/reimbursement-policies-guidelines/services-on-telemedicine-platforms> (“Reimbursement for telemedicine services . . . is limited to services involving the use of interactive, real-time, two-way audio-video communication technologies for the purpose of diagnosis, consultation, or treatment in accordance with the member’s contract.”).

184. Matthew Rae et al., *Coverage and Utilization of Telemedicine Services by Enrollees in Large Employer Plans*, HEALTH SYSTEM TRACKER (Mar. 3, 2020), <https://www.healthsystemtracker.org/brief/coverage-and-utilization-of-telemedicine-services-by-enrollees-in-large-employer-plans> (“While utilization of telemedicine remains low, employers are increasingly likely to cover these services and express continued interest in refining their approach.”); see also Bob Herman, *Virtual Reality: More Insurers Are Embracing Telehealth*, MODERN HEALTHCARE (Feb. 20, 2016, 12:00 AM), <https://www.modernhealthcare.com/article/20160220/MAGAZINE/302209980/virtual-reality-more-insurers-are-embracing-telehealth> (“More private insurers are paying for telehealth services, a trend experts say will boost relatively low levels of utilization.”).

coverage is possible because of flexible reimbursement models that private payers negotiate with providers¹⁸⁵ that escape the limited confines of the fee-for-service payment model embedded in the § 1834(m) regulatory landscape.

In public programs, however, adoption of telemedicine has been a slower process.¹⁸⁶ The regulatory structures that govern Medicare and Medicaid are responsive to those same externalities that motivate private payers to integrate telemedicine into their payment models, but defining characteristics of these health care programs, namely, their fee-for-service payment models, present challenges to implementation. This is particularly true for the more revolutionary forms of telemedicine in RPM and other forms of asynchronous care that were not anticipated by lawmakers who constructed these regulatory schemes.

The slow integration of telemedicine in public health care programs is concerning because beneficiaries of the Medicare and Medicaid programs are those who may have the most to gain from modern telemedicine. For example, seniors, covered by Medicare, often must visit their doctors more frequently than younger people, but also struggle with mobility.¹⁸⁷ Telemedicine would allow seniors to receive these services from the convenience of their homes, expanding access and, importantly, reducing costs. This cost-saving would occur throughout the senior-care system. For example, it is estimated that telemedicine would save the residents of the average nursing home \$151,000 per year due to reduced hospitalizations, savings that reduce the overall cost burden of the Medicare program.¹⁸⁸ Telehealth expansion would also help individuals with disabilities for much the same reasons.

185. Emily Sokol, *Private Payers Outpace Public Insurance in Value-Based Care Push*, REVCYCLE INTELLIGENCE (Sept. 28, 2020), <https://revcycleintelligence.com/news/private-payers-outpace-public-insurance-in-value-based-care-push> (reporting on industry surveys finding that private payers are far more likely to contract for value-based reimbursement models than their public payer counterparts).

186. *Id.*

187. Donald H. Taylor, Jr. & Helen Hoenig, *Access to Health Care Services for the Disabled Elderly*, 41 HEALTH SERV. RES. 743, 744 (2006) (“However, mobility limitations in particular might increase the need for medical care while hindering a person’s ability to access such care.”).

188. CTRS. FOR MEDICARE & MEDICAID SERVS., INFORMATION ON MEDICARE TELEHEALTH 20 (2018), <https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf>.

Meanwhile, the Medicaid program enrolls low-income individuals and families. Health care access is generally difficult for this population for a variety of reasons. In some areas of the country, many providers do not accept patients covered by Medicaid because of its low reimbursement rates relative to private payers.¹⁸⁹ Additionally, Medicaid enrollment in rural America is high.¹⁹⁰ These enrollees are even more vulnerable to the resultant lack of health care access when providers refuse to accept Medicaid payments,¹⁹¹ the negative effect of which compounds with the already low availability of practitioners in these communities.¹⁹² Finally, because of the Medicaid expansion, many individuals who may be Medicare eligible decide to enroll in Medicaid instead due to a more forgiving application process.¹⁹³ Therefore, many of those barriers to successful health care outcomes for Medicare beneficiaries also apply to those enrolled in Medicaid.¹⁹⁴

189. Esther Hing, Sandra L. Decker & Eric Jamoom, *Acceptance of New Patients with Public and Private Insurance by Office-Based Physicians: United States, 2013*, NAT'L CTR. HEALTH STAT., (Mar. 2015) <https://www.cdc.gov/nchs/data/databriefs/db195.pdf>; see also Les Masterson, *Doctors Less Likely To Accept Medicaid Than Other Insurance*, HEALTHCARE DIVE (Jan. 28, 2019), <https://www.healthcarediver.com/news/doctors-less-likely-to-accept-medicaid-than-other-insurance/546941/>; Sumit Agarwal, *Physicians Who Refuse To Accept Medicaid Patients Breach Their Contract with Society*, STAT NEWS (Dec. 28, 2017), <https://www.statnews.com/2017/12/28/medicaid-physicians-social-contract> (“[P]hysicians and administrators frequently blame the bureaucratic hassles of Medicaid, particularly its subpar reimbursements” for their unwillingness to serve Medicaid patients).

190. Julia Foutz, Samantha Artiga & Rachel Garfield, *The Role of Medicaid in Rural America*, KAISER FAMILY FOUND. (Apr. 25, 2017), <https://www.kff.org/medicaid/issue-brief/the-role-of-medicaid-in-rural-america> (finding about one in four adults in rural America to be enrolled in Medicaid).

191. See, e.g., Masterson, *supra* note 189 (noting that only 71% of healthcare providers accepted Medicaid patients, compared with 90% who accepted private insurance).

192. See discussion, *supra* Part I.B.i.a.

193. See *Medicaid Expansion*, NAT'L ALLIANCE ON MENTAL ILLNESS, <https://www.nami.org/Learn-More/Mental-Health-Public-Policy/Medicaid-Expansion> (last visited Feb. 21, 2021) (“By allowing people to qualify for coverage based on income, rather than a disability determination, Medicaid expansion removes barriers to coverage for many additional people with mental illness, helping them receive the mental health services they need to thrive in their communities.”).

194. See *Two Common Barriers in Medicaid—and How To Overcome Them*, HEALTHLEADERS MEDIA (Dec. 2, 2009), <https://www.healthleadersme>

Finally, Medicaid enrollees, coming from lower-income backgrounds, tend to have lower health literacy.¹⁹⁵ As such, they often only engage with the health care system after already becoming sick, utilizing preventative care at a far lower rate than individuals insured on the private market.¹⁹⁶ The result, of course, is poor health care outcomes for Medicaid enrollees,¹⁹⁷ as well as more severe costs experienced throughout the health care system.¹⁹⁸ Such outcomes are perhaps even understated, as much of the Medicaid-eligible population lives without coverage and simply enrolls when a health care crisis emerges.¹⁹⁹ Passive RPM technology may be specifically apt at monitoring and diagnosing such individuals with low health care utilization. Once a patient-doctor relationship is established, the onus no longer falls on a patient with low health literacy to monitor her own progress. Instead, a care team can passively monitor the individual's health care metrics and maintain a basis of communication with the patient in between visits. It is also likely that the circu-

dia.com/finance/two-common-barriers-medicaid-and-how-overcome-them (listing unstable housing and lack of access to reliable transportation as primary barriers to health care access for the Medicaid population).

195. Roopa Mahadevan, *Health Literacy Fact Sheets*, CTR. FOR HEALTH CARE STRATEGIES, <https://www.chcs.org/resource/health-literacy-fact-sheets> (Oct. 2013) (asserting that lower socioeconomic status and receipt of public health coverage correlate with low health literacy).

196. *See id.*; *see also* *Low Health Literacy Skills Increase Annual Health Care Expenditures by \$73 Billion*, HEALTH POLICY INST., GEO. U., <https://hpi.georgetown.edu/healthlit> (“When self-reported health status is taken into account, patients with low healthy literacy skills had fewer doctor visits but used substantially more hospital resources.”).

197. *See* WELLSOURCE, HEALTH LITERACY LINKED TO HEALTH OUTCOMES (2017), <https://go.wellsourc.com/hubfs/White-Papers/Health-Literacy-by-Wellsource.pdf>.

198. *See* HEALTH POLICY INST., *supra* note 196.

199. *See* MARTHA BURT ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAID AND PERMANENT SUPPORTIVE HOUSING FOR CHRONICALLY HOMELESS INDIVIDUALS: EMERGING PRACTICES FROM THE FIELD 23 (2014), <https://aspe.hhs.gov/system/files/pdf/77116/EmergPrac.pdf> (“Many [Medicaid] beneficiaries . . . have difficulty understanding the need to maintain coverage when they do not need care. They are accustomed to going to the doctor, emergency room, or hospital when they are sick . . . and do not see why they should worry about maintaining insurance coverage when they can always get re-enrolled on the spot when they need care again.”).

lar feedback structure of RPM and other asynchronous technology will promote improved engagement and compliance within these beneficiaries' health care plans.²⁰⁰

B. MEDICARE AND MEDICAID'S FEE-FOR-SERVICE REIMBURSEMENT MODEL CANNOT ADEQUATELY REIMBURSE PROVIDERS THAT UTILIZE TELEMEDICINE

The fee-for-service methodology that is predominant within both Medicare and Medicaid severely limits the expansion of telemedicine utilization in health care delivery. Within the fee-for-service reimbursement model, a given service must be represented by a singular, pre-negotiated code for the provider to be paid for that service, and the codes CMS has historically utilized fail to capture significant aspects of care delivered.²⁰¹ Despite recent efforts by CMS to better codify telemedicine services within both Medicare and Medicaid, such remedies still inadequately reimburse providers for innovative uses of telemedicine because they can only be reactive to technology and care delivery advancements that have already occurred. The inherent limitations created by necessitating services to qualify within pre-negotiated, standardized codes inhibits adopting of telemedicine into routine care, as providers cannot afford to be uncompensated for the services they deliver.²⁰²

i. Telemedicine Codification in Medicare

The recent expansion of telemedicine codification in Medicare demonstrates the shortcomings of fee-for-service reimbursement methodology. As technology has rapidly increased, and as consumer demand for telemedicine has grown,²⁰³ CMS

200. See Jessica Bartlett, *Study by Biogen, PatientsLikeMe Suggests Wearables Can Help MS Patients*, BOS. BUS. J. (Apr. 15, 2015, 12:01 AM), <https://www.bizjournals.com/boston/blog/health-care/2015/04/study-by-biogen-patientslikeme-suggests-wearables.html>.

201. See generally discussion, *supra* Part I.B.

202. Michael W. King, *Achieving Health Care Efficiencies Through Consolidation and Alternative Models: Irreconcilable Differences?*, BROWNSTEIN, HYATT, FARBER & SCHRECK (Feb. 9, 2017), <https://www.bhfs.com/Templates/media/files/insights/Achieving%20Health%20Care%20Efficiencies%20through%20Consolidation%20and%20Alternative%20Models%20-%20Irreconcilable%20Differences.pdf>.

203. KEN ABRAMS & CASEY KORBA, DELOITTE CTR. FOR HEALTH SOLS., CONSUMERS ARE ON BOARD WITH VIRTUAL HEALTH OPTIONS (2018),

has demonstrated concerted efforts to allow for the growth of this sector within Medicare. Restricted by the confines of § 1834(m), CMS in 2019 created a distinction between “Medicare telehealth services” and other services, which “might be called ‘telehealth’ by patients, other payers and health care providers,” but which CMS does not interpret to be under the § 1834(m) umbrella because they are not explicitly enumerated in the statute.²⁰⁴ The difference here is subtle:

Telehealth services are considered a substitute for an in-person visit, and are therefore paid at the same rate as it would have been had it been furnished in person. With some exceptions, telehealth services require the use of interactive audio and digital telecommunication systems that permit real-time communication between the practitioner at the distant site and the beneficiary at the originating site. The communication technology-based and remote evaluation services that we proposed are not a substitute for a visit, but are instead brief discussions . . . to determine if a visit is necessary.²⁰⁵

The created distinction, therefore, allows providers to triage patients via communication technology-based services, like synchronous, asynchronous, and some kinds of RPM technology, and receive reimbursement even if such communication does not result in a billable visit.

The new communication technology-based services codes CMS created allow for some telehealth technology to be integrated into routine care, but they still inherently limit practitioners in what care will be reimbursed. As technology continues developing in unanticipated ways, practitioners will always be hindered in leveraging that technology for the betterment of their patients’ health since new modalities of care are unlikely to fit within the strict confines of CMS’s pre-established codes. By requiring CMS to constantly reassess and modify these codes to be inclusive of the newest modalities of technology, practitioners are put years behind on the technology curve, and patients may not receive the best care available to them.²⁰⁶

https://www2.deloitte.com/content/dam/insights/us/articles/4631_Virtual-consumer-survey/DI_Virtual-consumer-survey.pdf (finding that a majority of survey respondents are willing to try virtual healthcare visits).

204. See generally Medicare Program Payment Changes and Telehealth Changes, 83 Fed. Reg. 59,452 (Nov. 23, 2018) (codified at 42 C.F.R. pts. 405, 410, 411, 414, 415, 425, and 495).

205. *Id.* at 59,685.

206. See *Process for Requesting New Codes or Modification of Existing Codes*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Feb. 11, 2020),

By way of example, we can consider changes that CMS made in its 2019 revision to the Medicare Physician Fee Schedule regarding payments for RPM, which it explicitly did outside of the § 1834(m) confines. Until 2018, general providers could only account for Remote Patient Monitoring with CPT Code 99091, a general code which was bundled into other management service codes and thus not separately reimbursable to the provider.²⁰⁷ In other words, whatever data management that occurred was essentially wrapped up with other administrative functions instead of treated as separate delivery of care.²⁰⁸ In 2018, CMS unbundled this code, allowing providers to bill separately for such a service and, in effect, recognizing data assessment and any resulting care as a form of health care delivery.²⁰⁹

However, even after this unbundling, requirements to get reimbursed were still quite restrictive, particularly as CMS only allowed reimbursement if practitioners reviewed, interpreted, or responded to data for at least thirty minutes within a thirty-day period.²¹⁰ Additionally, 99091 care could only be delivered by a physician or by a “Qualified Health Professional” (which usually requires professional licensure).²¹¹

Beginning in the year 2019, CMS enacted three new practice expense codes, applicable to RPM technology:

- CPT code 99453 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment).
- CPT code 99454 (Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days).
- CPT code 99457 (Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring

https://www.cms.gov/Medicare/Coding/place-of-service-codes/New_or_Modified_Codes (describing the process by which new codes may be recommended and considered).

207. Carrie Nixon, *How to Get Paid for Remote Patient Monitoring with CPT Code 99091*, NIXON LAW GRP. (Jan. 11, 2018), <https://www.nixonlaw-group.com/nlg-blog/2018/1/9/reimbursement-for-remote-patient-monitoring-cpt-99091>.

208. *See id.*

209. *Id.*

210. *Id.*

211. *Id.*

interactive communication with the patient/caregiver during the month).²¹²

These codes, which were proposed by the American Medical Association in 2017, were a clear improvement over the reimbursement available under 99091 in three ways.

First, CMS reimburses after only twenty minutes, rather than the thirty required under 99091.²¹³ While this difference may seem nominal, it is significant: since data aggregation occurs passively, caregivers often only assess the data when a medical threshold is triggered. Thirty minutes spent by a physician to interpret this data and virtually respond to it often is not necessary to respond to the patient's specific need.²¹⁴ As such, much of that care was left uncompensated. A lower temporal threshold better rewards providers that effectively utilize the technology.

Second, whereas CPT 99091 only reimburses "physicians and qualified health professionals," the newly enacted codes specifically allow clinical staff to conduct the described activities.²¹⁵ This is significant, since it is often not an effective use of resources for highly trained professionals to spend the time performing and documenting this sort of care.²¹⁶

Finally, the newly enacted CPT 99453 provides additional reimbursement for time spent setting up the RPM equipment and educating the patient on how it works.²¹⁷ This process can be time intensive, as informed consent can be difficult to acquire with the privacy and security risks inherent in mobile technology.²¹⁸ However, by allowing providers to get reimbursed for this

212. Medicare Program; Revisions to Payment Policies, *supra* note 204 at 59,492.

213. Nathaniel Lacktman, *Medicare's New Chronic Care Remote Physiologic Monitoring Codes: Everything You Need to Know*, FOLEY & LARDNER LLP (Aug. 1, 2018), <https://www.foley.com/en/insights/publications/2018/08/medicare-new-chronic-care-remote-physiologic-moni>.

214. *Id.*

215. *Id.* at 204 ("CPT 99091 is limited only to 'physicians and qualified health care professionals' and does not expressly allow the RPM service to be delivered by clinical staff The new CPT 994X9 allows RPM services to be performed by clinical staff.")

216. Lacktman, *supra* note 213.

217. Medicare Program; Revisions to Payment Policies, *supra* note 204 at 59,492.

218. See generally Nalin Amunugama et al., *Bringing Informed Consent into the Modern Age of Healthcare*, HOSP. & HEALTHCARE MGMT., <https://www.hhmglobal.com/knowledge-bank/articles/bringing-informed-consent-into-the-modern-age-of-healthcare> (last visited Mar. 19, 2021).

onboarding activity, CMS gave further incentive for providers to utilize telemedicine technology with new patients.²¹⁹

CMS's new "communication technology" codes demonstrate that by circumventing the restrictions of § 1834(m), regulators allow practitioners to get compensated for providing improved care to Medicare beneficiaries. However, one need not be imaginative to see how the above-described codes fall short of maximizing telemedicine's promise. For example, these codes only reimburse providers for curative care: providers only get reimbursed for using telehealth technology for treating sick patients. The value of technology that can be used to monitor patients and keep them healthy to begin with—technology that is rapidly advancing²²⁰—is not recognized. For example, in CPT 99457, a provider only gets reimbursed for monitoring the data collected if the provider has "interactive communication" with the provider during the month billed.²²¹ This requires providers to spend time interacting with a patient each month to get reimbursed for this monitoring, even if the patient is perfectly healthy, simply for the sake of getting paid by CMS.²²² Such perverse incentive results in unnecessary administrative burden and fails to serve the purpose of actually improving care.

CMS certainly could—and should—continue expanding these non-1834(m) codes to better capture the utilization of newer technology and to better allow health systems to achieve positive health outcomes. But a reactionary process wherein regulators must constantly consider novel mediums of telecommunications and health care delivery, conceive of new codes which reward those new technologies, and approve of those codes within the regulatory process is regressive and inadequate. Such a process is necessarily slow to recognize the modern advancements in telehealth technologies that consumers seek, providers could utilize, and from which patients could benefit. Further, the uncertainty surrounding CMS's willingness to reimburse for the

219. Lactman, *supra* note 213.

220. See generally discussion, *supra* Part I.A(ii)(2).

221. See N.Y.C. BAR ASS'N, NEW CMS INCENTIVES FOR REMOTE PATIENT MONITORING AND PATIENT ACCESS, 20190618P N.Y.C. BAR 74.

222. See Teresa Iafolla, *Medicare and Telemedicine: Top 10 FAQs*, EVISIT (Aug. 12, 2015), <https://blog.evisit.com/medicare-telemedicine-top-10-faqs> ("In almost all cases, Medicare only reimburses for live telemedicine – in other words, a real-time videochat between a physician and patient. The idea is to model a face-to-face visit as closely as possible. Medicare also reimburses for store-and-forward telemedicine services, but only in Hawaii and Alaska.").

most cutting-edge innovations is a market disincentive for the creation of telemedicine technology specifically tailored for medical application in integrated care.²²³ In this way, CMS's continued reliance on fee-for-service codification results in provider disincentive to utilize modern telemedicine with healthy patients, despite the long-term public health benefits.

ii. Telemedicine uniformity in Medicaid

Attempts to integrate telemedicine into Medicaid reimbursement is inherently more challenging because CMS cannot institute such changes unilaterally—rather, states control what services will be reimbursed. However, because Medicaid policy is federally approved, CMS should continue to demonstrate a clear willingness to approve waivers submitted by states that want to reimburse for telemedicine in their Medicaid system. Should it do so, a rapid expansion in telemedicine utilization could occur. Because state Medicaid programs are not bound by § 1834(m), states are ripe for this technology and generally more responsive to modern technological advances, as evidenced by the twenty states who already reimburse for remote patient monitoring.²²⁴

However, the complex variations between how states have chosen to reimburse for telemedicine has resulted in a glaring need for a uniform code. To this point, decades after telemedicine has grown more prevalent, no uniform code has been established, though the Uniform Law Commission in 2019 announced a Telehealth Committee which will “study the need for and feasibility of state legislation on telehealth.”²²⁵

223. Cf. Larry Beresford, *Don't Overlook Direct-to-Consumer Telehealth*, MEDPAGE TODAY (Dec. 14, 2020), <https://www.medpagetoday.com/practicemanagement/telehealth/90199> (describing the potential for growth of direct-to-consumer telemedicine technology if federal policymakers do not prioritize coverage expansion for federally funded programs after the end of the COVID-19 public health emergency).

224. See, e.g., Tanya Feke, *Medicare and Medicaid Coverage for Telemedicine*, VERYWELL HEALTH (Sept. 5, 2019), <https://www.verywellhealth.com/medicare-and-medicare-coverage-for-telehealth-4682549>.

225. Katie Robinson, *New Drafting and Study Committees*, UNI. L. COMM'N. (Feb. 07, 2019), <https://www.uniformlaws.org/committees/community-home/digestviewer/viewthread?MessageKey=38fe48dc-4afe-4119-9f03-efb16aa55fe3&CommunityKey=d4b8f588-4c2f-4db1-90e9-48b1184ca39a&tab=digestviewer>.

One of the largest impediments to telemedicine integration is providers' anxiety about not being reimbursed for the services they deliver.²²⁶ Such fears are only exacerbated when billing practices differ between public programs. As such, it is crucial that the Uniform Law Commission recommend codes that, at the very least, match the "communication technology" and other non-1834(m) codes that CMS has introduced for reimbursement. In this way, providers can have confidence when designing their practice that utilization of modern telehealth technology will be uniformly reimbursed.

C. A TRANSITION AWAY FROM FEE-FOR-SERVICE PAYMENT MODELS TOWARDS OUTCOME-BASED REIMBURSEMENT MODELS IS NECESSARY FOR THE MEDICARE AND MEDICAID POPULATION TO FULLY EXPERIENCE THE PROMISE OF TELEMEDICINE.

As telehealth technology becomes more ubiquitous, it has the potential to resolve many of our most pressing health care problems, from inequity in health care access, to inefficiencies of care coordination across providers, to low health care utilization and health literacy among people with unhealthy lifestyles.²²⁷ Meanwhile, advances in technology similarly promote an advance in policy: such technologies are increasingly available to meet many of the shortfalls of our health care system,²²⁸ but policy has not yet caught up to allow these technologies to be widely used, particularly within the Medicare and Medicaid programs.²²⁹ Due to higher rates of chronic and complex conditions within the Medicare and Medicaid population, as well as their relative immobility and barriers to health care access, Medicare and Medicaid beneficiaries are among those who could benefit

226. Clemens Scott Kruse et al., *Evaluating Barriers to Adopting Telemedicine Worldwide: A Systematic Review*, 24 J. TELEMED. TELECare 4, 4 (2018).

227. See Rashid L. Bashshur & Gary W. Shannon et al., *National Telemedicine Initiatives: Essential to Healthcare Reform*, 15 TELEMEDICINE & E-HEALTH 600, 602 (2009); see also *Alzheimer's Disease and Healthy Aging*, DIVISION OF POPULATION HEALTH, NAT. CTR. FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, <https://www.cdc.gov/agingabout/index.htm> (last visited on Dec. 1, 2019).

228. See, e.g., ACCENTURE, ACCENTURE TECHNOLOGY VISION 2015 7 (2015), https://www.accenture.com/_acnmedia/Accenture/Conversion-Assets/Microsites/Documents11/Accenture-Technology-Vision-2015.pdf.

229. Cf. King, *supra* note 33, at 306 (discussing potential reasons why telemedicine has not been more widely adopted).

most from the continued expansion of telemedicine.²³⁰ However, for enrollees to realize that benefit, Medicare and Medicaid should expand its value-based payment models to recognize and reimburse for all forms of care delivery.

i. Fee-For-Service Reimbursement Inadequately Reimburses for Telehealth Delivery

An inherent issue within telemedicine is that, in such an untraditional form of care delivery, certain aspects of care which cost providers time and resources will not be recognized by a billing code, and will therefore go uncompensated. This concern goes further than the complex regulatory landscape. Rather, providers fear that many activities that are tangential to actual care—for example, patient onboarding to services, more frequent incidental communications with patients, and data processing—will not properly fit in a given billing code.²³¹ Thus, providers will only get paid when the enrollee gets sick, rather than when the technology properly keeps the patient healthy. Put simply, from the provider standpoint, there is fear that the codification of virtual services does not provide sufficient flexibility to capture all of the activity that occurs in telemedicine delivery—particularly that activity, like RPM and data monitoring, that allows telemedicine to achieve better outcomes than traditional medicine.

At the same time, payers may fear that providers will utilize telemedicine services in addition to, rather than instead of, conventional medicine, leading higher costs for payers. Such is the subject of the CMS Office of the Inspector General’s Medicaid Services Delivered Using Telecommunications Systems report, originally expected to be issued in 2020.²³² While providers fear

230. Chapel et al., *supra* note 164, at 143; *The Role of Medicaid for Adults with Chronic Illnesses*, KAISER FAMILY FOUND. (Nov. 2012), <https://www.kff.org/wp-content/uploads/2013/01/8383.pdf>; *see also* Mariétou H. Ouayogodé et al., *Association Between Care Management and Outcomes Among Patients With Complex Needs in Medicare Accountable Care Organizations*, 2 JAMA NETWORK OPEN e196939–e196939 (2019).

231. *See, e.g.*, Ladika, *supra* note 101 at 15 (“[A] survey of more than 1,500 family physicians . . . found that almost 90% of respondents would [only] use telehealth to help treat their patients . . . if they were compensated for that care.”).

232. *See Medicaid Services Delivered Using Telecommunication Systems*, U.S. DEP’T. OF HEALTH AND HUMAN SERV. OFFICE OF INSPECTOR GEN., <https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary->

their telemedicine services will not be appropriately compensated, payers fear the slippery slope of allowing providers to bill for the smallest amount of virtual “care.”²³³ Because payers may have a hard time tracking what any individual billed service is supposed to represent outside of the traditional care setting, particularly when rapidly advancing technology allows for a highly individualized care plans, trepidation exists that opening up the delivery of telehealth care to public program enrollees will encourage fraud and abuse.²³⁴

ii. CMS should continue transitioning Medicare and Medicaid to value-based reimbursement in order to best achieve the promise of telemedicine

A variety of outcome-based reimbursement systems exist as an alternative to fee-for service payment models, and each allows for more flexibility to reward providers for telehealth services. These payment methodologies often work in conjunction with system delivery reforms that focus on value and outcomes.²³⁵ For example, Accountable Care Organizations (ACOs) allow providers to receive one capped payment for the year from the payer for each person included in the population that the ACO manages.²³⁶ ACOs, under the 2015 Next Generation ACO Initiative, may also apply for waivers to expand their delivery of services not normally recognized by CMS.²³⁷ On the other hand, payment bundling allows unassociated providers to partner and

0000259.asp (listing reports which “determine whether selected States’ Medicaid payments for services delivered using telecommunication systems were allowable in accord with Medicaid requirements.”).

233. See King, *supra* note 33, at 306–07 (“A persistent concern about telemedicine in a fee-for-service reimbursement model impedes the adoption of telemedicine by CMS and other payors because they fear that patient-consumers will simply use telemedicine in addition to—rather than instead of—existing consumption of in-person health care services, substantially driving costs up.”).

234. See *id.* (arguing the potential for fraud makes a fee-for-services model less desirable).

235. See generally AM. MED. ASS’N, *supra* note 120.

236. See Brent C. James & Gregory P. Paulson, *The Case for Capitation*, HARV. BUS. REV. 102, 102 (2016) (discussing a variety of health care cost control measures including ACOs).

237. *Medicare Reimbursement*, 3 HEALTH L. PRAC. GUIDE § 46:26, Westlaw (2020) (“[Q]ualified Next Generation ACOs may obtain a waiver from CMS under certain circumstances, of the requirement that beneficiaries be located in a rural area and at a specified type of originating site to be eligible for reimbursement of telehealth services.”).

provide a medical service at a bundled rate.²³⁸ This bundled payment specifically reimburses in response to an “episode-of-care,” meaning that providers receive a single negotiated payment for the entire bundle of services for a given condition or procedure, rather than individual payments for each separate item of care delivered.²³⁹ This saves resources in comparison to separate caregivers providing different aspects of care and billing the payer separately, and it also generates efficiencies because providers share the benefit from the savings they generate by treating and stabilizing a patient at a low cost.²⁴⁰ A variety of other options also exist: from “Shared Savings” systems, wherein providers are entitled to a share of the savings that result from their reduction in total health care spending below an expected level set by payer, to a more risk-driven “Capitation Model,” wherein providers receive a set payment for a specific medical service and inherit all of the risk or gain from the savings achieved.²⁴¹

Through whatever mechanism of fully integrated value-based care, the particularities of which exceed the purpose of this note, providers have incentive to limit costs because they get to keep a certain percentage of savings realized within the payment structure so long as they meet the quality standards.²⁴² It is therefore not necessary for telemedicine services to fit within a pre-negotiated code, nor is it required for a caregiver to satisfy administrative checklists, such as spending at least twenty minutes of live consultation to qualify for a payment as is necessary under current fee-for-service payments. Instead, because the provider is paid the same amount regardless of how she chooses to care for the patient, the efficiencies within telehealth technologies are automatically captured, and providers are thus encouraged to continue delivering similarly efficient care.

238. See Michael E. Porter & Robert S. Kaplan, *How to Pay for Health Care*, 2016 HARV. BUS. REV. 88 (arguing bundled payments should replace fee-for-service healthcare).

239. See VALENCE HEALTH, MODELS OF VALUE-BASED REIMBURSEMENT 2–3 (2013), https://web.archive.org/web/20180625180355/https://www.integration.samhsa.gov/about-us/VBP_White_Paper_-_Pros_and_Cons.pdf (discussing the benefits and drawbacks of “episode of care” healthcare payment).

240. See *id.*

241. See *id.* at 4–5 (discussing benefits and drawbacks of the shared risk and capitation healthcare payment).

242. See James & Paulson, *supra* note 236 (“If most or all of the money goes to health care payers, providers have no incentive to cut waste.”).

In addition to continuing to enact new non-1834(m) codes, CMS's priority in advancing telemedicine policy should be to continue the growth of ACOs and other value-based payment models, like the Advanced Alternative Payment Models promulgated by CMS's Innovation Center.²⁴³ However, such models have been conducted solely under a trial basis and have not been implemented at a scale that has demonstrated general applicability to all Medicare providers.²⁴⁴ For long-term viability, it seems necessary for CMS to engage with diverse providers—both large and small—and commit to long-term investment, providing financial protections to providers as they transition their care models rather than jeopardizing public health goals by prioritizing short-term savings. Finally, the Merit-based Incentive Payment Systems utilized by 90% of Medicare providers through the QPP awards providers based on outcomes,²⁴⁵ but its incentives are strictly attached to the fee-for-service payments that providers are receiving. In other words, as a value-based payment model, MIPs are not fully integrated—the gaps that exist due to fee-for-service payments persist. For public program beneficiaries to fully experience the benefits of telemedicine technology, the initiatives advanced by CMS and its Innovation Center must be divorced from such traditional payments and fully embrace value-based models.

Fully integrated value-based models would alleviate the tension between providers and payers as to what specific services will get reimbursed and what telemedicine activities will get lost in the fray. Instead, value-based payments would allow providers to utilize advances in telehealth technology in dynamic ways, improving health care outcomes and lowering health care costs for the populations with the highest health disparities. While fee-for-service reimbursement is inherently regressive—with CMS responding to advances in technology and in public health with new codes each year²⁴⁶—value-based payments stay

243. See discussion, *supra* Parts I.B(i)(b), I.B(ii)(b).

244. See Micklos et al., *supra* note 75 (discussing the history of innovation center model trials).

245. See discussion, *supra* Part I.B(i)(b), I.B(ii)(b).

246. See, e.g., Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment

ahead of the curve. Because the per-capita reimbursement is set in advance, providers are encouraged to utilize new, cost-efficient technologies as soon as they are approved for public use.

While fears exist that providers within value-based payment models would provide worse care in order to achieve short-term savings,²⁴⁷ these concerns are overblown. First, should providers take that “cheap route” to the detriment of their patient’s health, the provider will ultimately be the one to bear the cost—if patients achieve poorer health outcomes than expected, the financial brunt of that care will be felt by the provider itself, since the risk is allocated to them. Therefore, providers will have incentive to maximize care efficiency and effectiveness and ensure compliance with care plans. This compounds with changes to public perception of health care costs: societal attention to quality of care creates greater market pressure to achieve positive outcomes.²⁴⁸ Second, there exists ample remedies in tort law to hold providers liable who give negligent care, as well as institutions which fail to promote adequate procedures to ensure quality outcomes are achieved.²⁴⁹ While any litigation would likely

Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule, 84 Fed. Reg. 62,568 (Nov. 15, 2019) (to be codified at 42 C.F.R. pts. 403, 409, 410, 411, 414, 415, 416, 418, 424, 425, 489, 498) (enacting new telemedicine codes that strictly apply to opioid treatment).

247. See, e.g., *Are Medicare ACOs Working? Experts Disagree*, KAISER HEALTH NEWS (Oct. 21, 2015), <https://khn.org/news/are-medicare-acos-working-experts-disagree/> (quoting Jeff Goldsmith, President of Health Futures, Inc., “[L]ess than a fifth of the ACOs generate the vast majority of savings, and those failing to generate [outcome based] bonuses outnumber bonus winners three or four to one.”).

248. See Moody’s Investors Service, *Moody’s: Risk Management in Technology and Finance Now a Cornerstone Strategy for US NFP Hospitals*, MOODY’S (May 22, 2017), https://www.moody.com/research/Moodys-Risk-management-in-technology-and-finance-now-a-cornerstone—PR_367107 (“The relationship between quality of care and operating margins is increasingly linked. The perception of poor quality or management can have a lasting negative impact on an organization’s brand and patient demand, and adversely affect profitability.”).

249. See, e.g., BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS AND PROBLEMS*, 155–81, 207–58 (8th ed. 2018). While arguments may exist that overreliance on tort when thinking about system design is not efficient, the presence of those torts themselves, along with the cost of provider liability insurance when adequate procedures are not in place, should act as a motivating

occur between providers and private payers, the resultant internal standards and procedures that would emerge from providers delivering telemedicine would be to the benefit of public program beneficiaries.

Ultimately, under fee-for-service payments, providers would be “punished” by lack of reimbursement for using the most modern telemedicine applications available. They therefore resort to utilizing whatever methods are formally approved by payers through the coding process. On the other hand, fully integrated value-based payment models reward providers who utilize these technologies to meet the health disparities that exist and achieve the greatest health care outcomes possible. These are the ultimate goals of public health, and it should be CMS’s imperative to work towards them.

D. A BAND-AID SOLUTION: CMS’S TEMPORARY REIMBURSEMENT FOR TELEMEDICINE DURING THE COVID-19 PANDEMIC SHOULD CONTINUE AFTER THE END OF THE PUBLIC HEALTH EMERGENCY

While CMS should ultimately adopt widespread value-based reimbursement, such enormous change cannot happen overnight. Yet CMS’s reaction to the emergency of the COVID-19 pandemic and the necessities of delivering care from afar shows that, even as we transition away from fee-for-service payments, changes can be made to the current regulatory landscape to better allow providers and patients to utilize the technology available to them.

As social distancing became a necessary precaution to the pandemic, CMS announced that “there is an urgency to expand the use of [telehealth] technology to help people who need routine care.”²⁵⁰ In order to ensure that “all Americans” can utilize “easy-to-use, accessible benefits,” CMS waived its § 1834(m) re-

stimulus for providers to maintain their quality of care. JOINT COMM’N. ON ACCREDITATION OF HEALTHCARE ORGS., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR IMPROVING THE MEDICAL LIABILITY SYSTEM AND PREVENTING PATIENT INJURY 4–5 (2005), https://www.jointcommission.org/assets/1/18/Medical_Liability.pdf (discussing the implications of medical liability and suggested alternatives); see also Michael Frakes & Anupam B Jena, *Does Medical Malpractice Law Improve Health Care Quality?*, 143 J. PUBLIC ECON. 142, 142–58 (2016), <https://doi.org/10.1016/j.jpubeco.2016.09.002> (reviewing the effect of negligence standards on healthcare outcomes and physician error).

250. *Medicare Telemedicine Health Care Provider Fact Sheet*, *supra* note 36.

restrictions so that all providers and all patients could take advantage of the technology.²⁵¹ CMS could only waive these restrictions due to the federal government's declaration of a Public Health Emergency; the restrictions will go back in place as the COVID-19 Public Health Emergency has subsided.²⁵² That CMS must waive an entire portion of its regulatory scheme in order to ensure that Americans can utilize telemedicine technology during a crisis is demonstrative of how that scheme is not suited to allow modern telemedicine to expand and thrive.

The policy goals for which CMS advocated in its release—that health care be accessible and easy-to-use—do not hinge on whether there is a pandemic. Public health is benefitted regardless of circumstances when patients have ease of access to their providers, and providers are empowered when clinicians can meet patients where they are.²⁵³ When the Public Health Emergency has ended, providers will be equipped with the tools to deliver telemedicine, and the practice of engaging with a care provider will be normalized among patients, but a regulatory scheme will remain in place that acts as a disincentive for those interests to connect. It should therefore be a priority of Congress to make modifications to § 1834(m) to allow the temporary changes CMS has made to its Medicare reimbursement to become permanent.²⁵⁴ Likewise, CMS should encourage states to continue utilizing this flexibility in their state Medicaid programs. Such changes would allow providers to continue utilizing the telemedicine infrastructure it has developed during the pandemic, allow states to develop policy to protect their interests after the transition,²⁵⁵ and allow patients to have access to the benefits telemedicine has to offer.

251. *Id.*

252. *See id.*

253. *See generally* Kocher, *supra* note 11 (arguing increased usage of telehealth is desirable).

254. *See, e.g.*, Matthew Shatzkes & Ehiguina Borha, *The Permanency for Audio-Only Telehealth Act: A Matter of Healthcare Equity?*, LEXOLOGY (Dec. 7, 2020), <https://www.lexology.com/library/detail.aspx?g=55c64a0d-6999-4e63-9ced-ad194bd8153f> (discussing the Permanency for Audio-Only Telehealth Act, introduced to Congress in December 2020).

255. *See, e.g.*, *Legal Considerations*, U.S. DEP'T. OF HEALTH AND HUMAN SERV., <https://telehealth.hhs.gov/providers/legal-considerations/> (last visited Feb. 9, 2021) (describing additional legal considerations for telehealth delivery, including protection of patient privacy and the licensure of interstate telemedicine delivery).

III. CONCLUSION

Telemedicine is transforming the way in which health care will be delivered. The future that *The Jetsons* depicted²⁵⁶ was fast-tracked by the COVID-19 pandemic, and we ought not waste the opportunity to make care more effective and accessible, particularly for those enrollees in Medicare and Medicaid which may have the most to gain from the growth of telemedicine. The fee-for-service reimbursement models under which Medicare and Medicaid currently operate are inadequate to properly pay providers for utilizing such dynamic technology. However, value-based payment structures, for which CMS, many states, and health care advocates have already advocated, capture the value that telemedicine technology introduces and properly reimburse providers who successfully leverage that technology. While an adoption of less restrictive fee-for-service policies, like those installed during the COVID-19 public health emergency, would allow our health care system to continue developing telemedicine infrastructure, more profound reform—namely the adoption of value-based reimbursement methodologies—would allow Medicare and Medicaid beneficiaries to best benefit from the transformative potential that telemedicine presents.

256. At least those aspects relating to telemedicine.