Issue: MI Healthcare

Telemedicine: To See or Not to See?

Ensuring equity in virtual healthcare

The age of COVID-19 will be remembered as a time of loss, sacrifice, economic chaos, and courage. It will also be seen as a time when medical innovation and the search for new cures and creative means to deliver health services exploded. Telemedicine is one of those expanding delivery capabilities, representing both promise and problems for caregivers and their patients. It is this challenge—the delivery of fast, effective virtual medical care in metropolitan as well as rural settings, without disaffecting patients, medical professionals, and insurers, that state and local governments now have to face head on.

Background

Viewed as a relatively recent innovation, telemedicine has actually been around for over 50 years, dating back to the 1960's when it was first used to monitor and manage the health of astronauts in space.[1] Yet its efficacy has only been acknowledged in a strictly defined set of health services which have evolved slowly since its introduction. The pace of that evolution, however, has dramatically expanded with the exigency of COVID-19 and the need to treat highly contagious persons separately from those with non-coronavirus illnesses—many of whom may have critical conditions themselves.

In the space of just three months, for example, the University of Michigan's Michigan Health telemedicine video visits have seen a five-fold increase from 444 in February to 6,800 in March, and to over 20,000 video visits through April 24, 2020. Clinicians are predicting that these numbers will continue to rise, with Michigan Medicine recently receiving a $649,000 grant to expand their telehealth services even further.[2]

Definitions of telemedicine and reimbursement of health-related fees under insurance varies widely by state. Those definitions and covered services have also been evolving at lightning speed to meet the current pandemic crisis. In its broadest terms, the state of Michigan legislature defines **telehealth** as:

> The use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. Telehealth may include, but is not limited to, telemedicine.[3]

Telemedicine, then, is simply defined as, "The use of telecommunication technology to connect a patient with a health care professional in a different location."[4]

And that is where "simple" definitions end. The legal, regulatory, patient access and payment provisions of those terms are, in reality, highly complex and often contradictory across states. (See *Appendix A* for additional State of Michigan telemedicine-related definitions.)

According to the Federation of State Medical Boards, an analysis of the myriad of telemedicine policies and definitions across state medical boards yields the following variations:[5]

Licensure

- 49 state boards, plus D.C., Puerto Rico, and the Virgin Islands, require physicians engaging in telemedicine be licensed in the state in which the patient is located.
- 12 state boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines to allow for the practice of telemedicine.

6 state boards require physicians to register if they wish to practice across state lines.

Reimbursement - Medicaid

- All states and the District of Columbia provide reimbursement for some form of live video in Medicaid fee-for-service. - *Just expanded for Michigan*
- 14 states reimburse for store-and-forward (transmission of medical information). - *Just expanded for Michigan*
- 22 states reimburse for remote patient monitoring. - *Just expanded for Michigan*
- 8 states reimburse for all three, with certain limitations.

Reimbursement – Private Payer

- 40 states and the Dist. of Columbia govern private payer telehealth reimbursement policies.
- 6 states have private payer parity laws.

Michigan Telemedicine Gaining Ground

Michigan has historically had a number of restrictive laws in place limiting access to telemedicine. Substantive progress was made, however, with the unanimous passage of a suite of bills by the House of Representatives on May 13, 2020, which has now progressed to the Senate for consideration.[6] [7]

Allowable Telemedicine Services

Per the Michigan Department of Health and Human Services (MDHHS) Medicaid definitions, subject to the licensure and reimbursement terms above, the following services are allowed via telemedicine:

- End Stage Renal Disease services
- Behavior change intervention (smoking cessation)
- Behavioral Health &/or Substance Use Disorder
- Education Services
- Remote Retinal Imaging, DX and Management
- Inpatient consultations
- Nursing facility subsequent care
- Office or other outpatient consultations
- Office or other outpatient services
- Psychiatric diagnostic procedures
- Subsequent hospital care
- Training service (Diabetes Self-Management
- Telehealth Site Facility Fee

Source: MDHHS https://www.michigan.gov/documents/mdhhs/Telemedicine_2019_671338_7.pdf

Like most states, Michigan requires a physician to be licensed in the state where their patient is located—even for limited telemedicine engagements. Unlike a number of other states, however, they cannot apply for a special purpose license limited to telemedicine, nor do they have the option of registering elsewhere if they want to engage across state lines. That means that a patient who might be out of state for any period of time is technically prohibited from having a telemedicine appointment with their regular doctor, even if the appointment qualifies as a reimbursable telemedicine service.[8]

Until very recently, Michigan was behind the curve in approving reimbursement for remote patient monitoring (RPM)—using digital devices to capture health data remotely and transmitting it securely to health care providers for assessment.[9] But the passage of the recent Telemedicine access measures in May—assuming the Senate follows the House's lead—will remove a number of key barriers. RPM includes services such as remote in-home devices to monitor blood sugar, blood pressure, vital signs, heart rate, electrocardiograms, and blood oxygenation levels—a critical component of COVID-19 care.

By denying reimbursement for these RPM technologies, states miss the opportunity to allow providers the ability to track healthcare data remotely for a patient released to go home or to a care facility, which reduces readmission rates.[10] Moreover, in cases like COVID-19, remote monitoring can

help prevent hospitals from becoming overwhelmed by keeping infected persons at home unless or until vital signs indicate hospital admission is actually required.

Michigan's Medicaid program was similarly just expanded to allow for telehealth appointments via live *and recorded* video conferencing sessions as reimbursable expenses.[11] As of May 13, 2020, Michigan will now reimburse for the cost of "store-and-forward" services, such as collecting basic clinical information including medical history, laboratory reports, or images and then sharing that information electronically with another clinician for evaluation,[12] thus patients will no longer have to transfer that data themselves or bear the duplication cost.

Allowable Telemedicine Locations

While "telemedicine" would imply that a patient is able to receive remote services at home, thereby avoiding the need to travel and/or limiting exposure to other people, that was not the case until May 2020 of this year when private homes were recognized as allowable places to receive services. Until this month, the MDHHS required that a patient receiving such services be restricted to one of the following sites:

- County mental health clinic or publicly funded mental health facility
- Federally Qualified Health Center
- Hospital (inpatient, outpatient, or critical access hospital)
- Office of a physician or other practitioner (including medical clinics)
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites)
- Rural Health Clinic
- Skilled Nursing Facility
- Tribal Health Center

Source:, https://www.michigan.gov/documents/mdhhs/Telemedicine_2019_671338_7.pdf ,pg. 7

Also on the more progressive side, Michigan has had a private insurance parity law in place since 2012 which requires payers to cover live video telemedicine sessions at the same rate as in-person services. They also loosened restrictions a bit further in 2014 when they removed mandated distance restrictions as an eligibility requirement to receive virtual care.[13] Additional details on this legislation, as well as the recent measures to bring telemedicine into the 21st century, are contained in *Appendix B - Telemedicine Legislation.*

Benefits and Overcoming Barriers

Given the depth and breadth of healthcare services now possible through telemedicine, it is more critical than ever that those services be made available equitably across the state. While its promise for poorer rural populations facing a dearth of local healthcare providers is obvious, the ability to deliver those services via robust, affordable telecom capacity is problematic. And while urban and suburban residents may have access to the broadband networks required for access, that does not mean that they can afford the computers or smart phone technology needed to access those service providers, nor can many afford the substantial data rates they engender.

From a healthcare provider perspective, the upside of telemedicine is multifold: faster, more pervasive access to health care professionals and specialists better able to reach our aging, at-risk and remote populations. Were telemedicine more accessible, emergency rooms could avoid overcrowding caused by unnecessary visits for non-urgent patients since they would no longer be the only option available. Highly communicable cases could be diagnosed more safely and efficiently from remote locations, only needing to come into a facility when remotely monitored vital signs indicate critical care is required. Similarly, primary care providers would carry less of a burden for run-of-the-mill maladies, better able to focus on patients that require high touch, interactive appointments. Finally, from a healthcare administration perspective, pervasive telemedicine could not only help offset the chronic shortage of physicians and other healthcare workers by making them more efficient, but also mitigate the time-consuming drudgery of extensive record-keeping requirements of healthcare insurers and medical billing provisions alike.

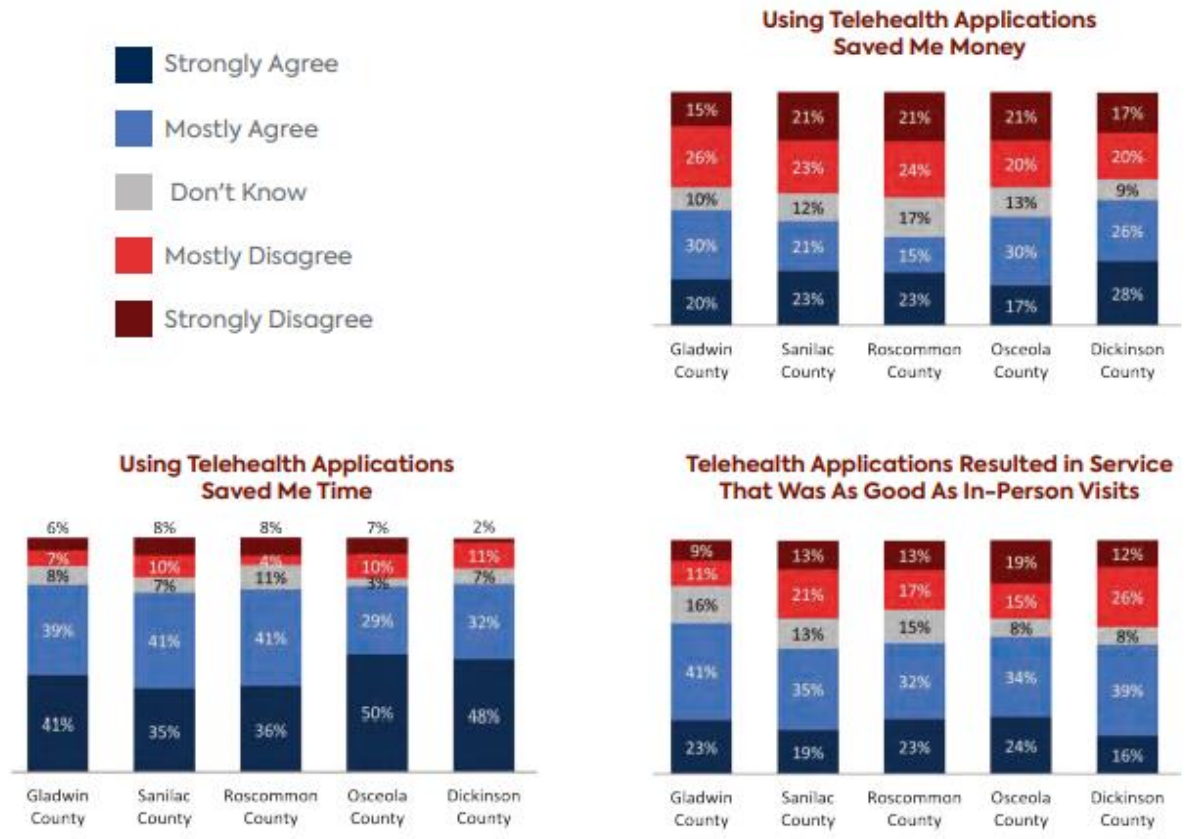
An extensive study about the benefits, barriers, and solutions to sustainable telehealth care in Michigan was just published in February 2020.[14] Supported by the Michigan Health Endowment Fund, "*Healthcare From Anywhere - Telehealth Use & Perceptions in Rural Michigan*" spells out detailed service availability and perceptions that must be addressed to ensure its success. While their focus is on rural healthcare, their findings regarding telehealth and telemedicine provisioning are applicable across the state.

The financial savings to patients and productivity time with telemedicine available is profound. According to the study, of those survey respondents who reported that online interaction saved trips to the doctor/medical center:

> Those who had fewer trips thanks to online interactions saved an average of 4.8 trips per household. In these five counties, for simple 15-minute visits to general practitioners, telehealth usage represents a savings of nearly $4.7 million per year, just for routine visits with healthcare professionals.[15] With studies showing that the average doctor's visit requires approximately two hours between travel, waiting rooms, and the visits themselves,[16] that represents nearly $1 million ($985,000) in additional lost productivity per year,[17] totaling a savings of $5.7 million per year in these five counties alone.[18]

Other benefits perceived by the Michigan survey participants include:[19]

Figure 9.
Telehealth User Impressions



Recommended Solutions

If the benefits of telemedicine are obvious, then why is the service not growing at an even faster pace? Transitioning to any new delivery capability has a learning curve, and some resistance to change based on age-old medical practices on the part of providers and patients are to be expected. But the barriers to a more robust rollout are actually more substantial, requiring legislators to take a deep look on behalf of their constituents.

Key findings by the aforementioned *Healthcare From Anywhere - Telehealth Use & Perceptions in Rural Michigan* study on telehealth deployment issues and recommended solutions focus on six major areas:[20]

Issue 1: Broadband Access

Access to, and use of, home broadband service is too low, particularly in rural areas, making it less likely that residents can use telehealth services at their homes.

Recommendations:

- Michigan should follow through on the steps laid out in the Michigan Broadband Roadmap.[21]
- Michigan should support the creation and dissemination of content to educate residents about how to access and use the internet.
- Michigan should collaborate with local leaders, educators, libraries, and other Community Anchor Institutions to identify local technology information gaps and work toward closing those gaps.

Issue 2: Data Security

Rural Michiganders have concerns about the safety of their online information, particularly the type of sensitive data that is shared through telehealth applications.

Recommendations:

- Tap into the knowledge base of educators at Michigan colleges and universities to determine the best methods to teach the public about online data security to help them feel more comfortable with using telehealth applications.
- Support opportunities for residents to learn more about online safety, as increased digital skills training results in a greater sense of control over what information is shared, and with whom.
- Provide opportunities for healthcare providers to share what steps they are taking to protect consumer information.

Issue 3: Inconsistent/Lesser Reimbursement

Telehealth services are not reimbursed or are reimbursed at lower rates than in-person healthcare services, creating a financial disincentive to expand the provision of telehealth offerings. This promotes less-efficient use of Medicare/Medicaid dollars as more patients are directed to emergency rooms, rather than taking preventative measures beforehand.

Recommendations:

- Conduct a cost-benefit study to determine how much (if anything) can be saved by increasing reimbursement options for telehealth services.
- Strengthen legislation to update definitions and provide stricter penalties that will ensure greater guidance and create greater deterrence to Medicaid and insurance fraud through telehealth services, ensuring such activities will be reined in.
- Adopt both coverage and reimbursement parity policies for Medicaid services.
- Adopt reimbursement parity policies for Michigan patients covered under private insurance.

Issue 4: Providers Expansion Funding

Healthcare providers need additional funding to support the expansion and improvement of offered telehealth services.

Recommendations:

- Create opportunities where healthcare network experts can identify and benefit from state and federal grants.
- Bring healthcare providers together to help share best practices regarding applying for and using available grants.

Issue 5: Nonintegrated Systems

Telehealth technology systems are not integrative. Typically health systems that want to provide telehealth services must adopt/learn new tools and procedures for each telehealth application, and often those applications do not mesh with telehealth tools being used at other health networks, reducing the ability to share information.

Recommendations:

- Encourage institutions of higher learning to create better telehealth software and hardware that can be integrated with a variety of health systems.
- Intentionally work to make Michigan's public universities a hub for medical technology engineering and programming through post-doctorate educational offerings, hiring decisions, and state funding.
- Encourage private-sector engineering and software design firms to focus on this issue through tax abatements, funding, and promotion to national and international markets via the Pure Michigan Business Connect initiative.

Issue 6: Inconsistent Support/Central Clearinghouse

Support for telehealth services in Michigan is scattershot, relying on a handful of national organizations and constant monitoring by a variety of sources to stay up to date.

Recommendations:

- Designate an office, individual, or neutral non-profit entity that will provide information about telehealth resources to healthcare networks and patients.

- Support and fund research to determine the economic and sociological impact of using telehealth applications in the state as well as best practices in telehealth service provision.

Telemedicine and HIPAA

In addition to the above, states will continue to have to monitor evolving federal regulations surrounding telemedicine and patient privacy protections under Health Insurance Portability and Accountability Act (HIPAA) regulations. Per the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS), a number of waivers have been *temporarily* granted during the COVID-19 crisis, as follows.[22]

Medicare & Medicaid Temporary Waivers

CMS has issued temporary measures to make it easier for people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) to receive medical care through telehealth services during the COVID-19 Public Health Emergency.

Some of these changes allow providers to:

- Conduct telehealth with patients located in their homes and outside of designated rural areas
- Practice remote care, even across state lines, through telehealth
- Deliver care to both established and new patients through telehealth
- Bill for telehealth services (both video and audio-only) as if they were provided in person

Temporary expansion of services

During the public health emergency, Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as distant telehealth sites and provide telehealth services to patients in their homes. CMS significantly expanded the list of covered telehealth services that can be provided in Medicare through telehealth to include:

- Emergency department visits
- Initial nursing facility and discharge visits
- Home visits
- Therapy services

Source: https://www.hhs.gov/coronavirus/telehealth/index.html

Summary

In short, there are countless ways legislators can help constituents achieve cost savings and health efficacy through more pervasive adoption of telemedicine. Whether it is fighting for better broadband access, cheaper 5G technology options, and creating more internet hotspots accessible to remote populations, improving consistency of Medicaid definitions, fighting for continued flexible-yet-secure HIPAA-compliant access, insurance regulatory reform, or simply efforts to better familiarize families with the benefits available, the role of state government in assuring its adoption is paramount. Taking on even one of these fights will yield returns for the very people who may be the most vulnerable in the state.

Appendix A - Telemedicine-related Definitions

The state of Michigan defines telehealth, telemedicine, telepractice, and related services as follows:[23]

Telehealth: "Telehealth means the use of electronic information and telecommunication technologies to support or promote long-distance clinical health care, patient and professional health-related education, public health, or health administration. Telehealth may include, but is not limited to, telemedicine."[24]

Telemedicine: "Telemedicine is the use of telecommunication technology to connect a patient with a health care professional in a different location."[25]

Telepractice: "Telepractice is the use of telecommunications and information technologies for the provision of psychiatric services to Assertive Community Treatment Program (ACT) consumers and is subject to the same service provisions as psychiatric services provided in-person."[26]

Appendix B – Key Telemedicine Legislation

Year	Topic	Bill	Synopsis	Party of Sponsor	Vote (if any) and Status
2012	Telemedicine Parity	HB5408 SB 753	Telemedicine "parity" law, prohibits private insurance companies from denying health insurance reimbursements for covered diagnoses, care and education that is "appropriately provided" via "telemedicine" rather than through face-to-face contact. https://www.legislature.mi.gov/(S(xsuonhmmhgmrv33vjnx5hq4k))/mileg.aspx?page=getobject&objectname=2012-HB-5408	Repub	Passed House 109Y (62R, 47D) 0 N 1 Nonvoting Passed Senate 38Y (26R, 11D)
2013	Telemedicine Removes Distance Restrictions	N/A	MDCH Coverage Effective October 1, 2013, there are no distance requirements between the originating and distant site when providing telemedicine services for Fee-For-Service (FFS) Medicaid beneficiaries. Michigan Dept. of Community Health Bulletin Number MSA 13-34	MI Medicaid Program	N/A
2016	Telemedicine Patient Consent	SB753	Protects patients' concerns with privacy and quality of care, must opt-in to receive telemedicine. Sec. 16284. "Except as otherwise provided in this section, a health professional shall not provide a telehealth service without directly or indirectly obtaining consent for treatment." https://www.legislature.mi.gov/(S(1kzf5xq3lbk141lildryoi05))/mileg.aspx?page=getObject&objectName=2016-SB-0753	Repub	Passed Senate 36 Y (27R 9D) 0 N 1 Excused Passed House 108Y (61R, 47D) 0 N
2020	Telemedicine Access In-home or In-school	HB5412	Amends state Insurance Code to include "store and forward online messaging" as a telemedicine service, removing the requirement that such services be delivered in real time. http://www.legislature.mi.gov/(S(enuw0dnskqvnr2y0w5uqd5uq))/mileg.aspx?page=GetObject&objectname=2020-HB-5412	Repub	Passed House 105Y (58 R,47 D) 0 N 4 Nonvoting

2020	Telemedicine Access In-home or In-school	HB5413	Amends state Nonprofit Health Care Corporation Reform Act (which governs Blue Cross Blue Shield) to include "store and forward online messaging" as a telemedicine service, removing the requirement that such services be delivered in real time. http://www.legislature.mi.gov/(S(enuw0dnskqvnr2y0w5uqd5uq))/mileg.aspx?page=GetObject&objectname=2020-HB-5413	Repub	Passed House 105Y (58 R,47 D) 0 N 4 Nonvoting
2020	Telemedicine Access In-home or In-school	HB5414	Amends state Mental Health Code to include "store and forward online messaging" as a telemedicine service, removing the requirement that such services be delivered in real time. http://www.legislature.mi.gov/(S(enuw0dnskqvnr2y0w5uqd5uq))/mileg.aspx?page=GetObject&objectname=2020-HB-5414	Repub	Passed House 105Y (58 R,47 D) 0 N 4 Nonvoting
2020	Telemedicine Access In-home or In-school	HB5415	Revises state Social Welfare Act (Medicaid) to add remote patient monitoring (RPM) services, defined as "digital technology to collect medical and other forms of health data from an individual in one location and electronically transmit that information securely to a health care provider in a different location for assessment and recommendations. http://www.legislature.mi.gov/(S(enuw0dnskqvnr2y0w5uqd5uq))/mileg.aspx?page=GetObject&objectname=2020-HB-5415	Dem	Passed House 105Y (58 R,47 D) 0 N 4 Nonvoting
2020	Telemedicine Access In-home or In-school	HB5416	Expands Medicaid coverage for telehealth visits to allow access in a home or school (vs. medical facility) as allowable patient settings http://www.legislature.mi.gov/(S(enuw0dnskqvnr2y0w5uqd5uq))/mileg.aspx?page=GetObject&objectname=2020-HB-5416	Repub	Passed House 105Y (58 R,47 D) 0 N 4 Nonvoting

[1] https://chironhealth.com/blog/telemedicine-facts-may-surprise/

[2] https://healthblog.uofmhealth.org/health-management/caring-at-a-distance-telehealth-and-covid-19-pandemic

[3] http://www.legislature.mi.gov/(S(xda5qehrfolkzxcbz5ohuoja))/mileg.aspx?page=getObject&objectName=mcl-333-16283

[4] MI Dept. of Community Health, Medicaid Provider Manual, p. 1670, Jan. 1, 2020 (Accessed Mar. 2020). http://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf.

[5] http://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf

[6]https://www.govtech.com/policy/Michigan-House-Passes-Series-of-Telehealth-Expansion-Bills.html

[7] https://mhealthintelligence.com/news/michigan-lawmakers-look-to-expand-rpm-store-and-forward-telehealth

[8] http://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf, page 1

[9] http://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf, page 5

[10] https://www.cchpca.org/about/about-telehealth/remote-patient-monitoring-rpm

[11] https://evisit.com/state-telemedicine-policy/michigan/

[12] https://visuwell.io/telemedicine-reimbursement/#

[13] https://evisit.com/state-telemedicine-policy/michigan/

[14] https://connectednation.org/wp-content/uploads/2020/03/CN_TELEHEALTH_2020_022720_FINAL-2.pdf

[15] Based on per-visit costs provided in the healthcare bluebook (https://www.healthcarebluebook.com/) as of December 2019.

[16]https://www.ajmc.com/journals/issue/2015/2015-vol21-n8/opportunity-costs-of-ambulatory-medical-care-in-the-united-states

[17] Based on Michigan's median hourly wage of $18.08 per hour (source: https://www.bls.gov/oes/current/oes_mi.htm#00-0000)

[18] https://connectednation.org/wp-content/uploads/2020/03/CN_TELEHEALTH_2020_022720_FINAL-2.pdf, page 67

[19] https://connectednation.org/wp-content/uploads/2020/03/CN_TELEHEALTH_2020_022720_FINAL-2.pdf, page 68

[20] https://connectednation.org/wp-content/uploads/2020/03/CN_TELEHEALTH_2020_022720_FINAL-2.pdf, pages 83-96.

[21] https://www.michigan.gov/documents/mdard/Aug_22_Meeting_Materials_630781_7.pdf

[22] https://www.hhs.gov/coronavirus/telehealth/index.html

[23] https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies/michigan-medicaid-definition

[24] http://www.legislature.mi.gov/(S(xda5qehrfolkzxcbz5ohuoja))/mileg.aspx?page=getObject&objectName=mcl-333-16283

[25] MI Dept. of Community Health, Medicaid Provider Manual, p. 1670, Jan. 1, 2020 (Accessed Mar. 2020).

[26] MI Dept. of Community Health, Medicaid Provider Manual, p. 356 Jan. 1, 2020 (Accessed Mar. 2020).