How telehealth care exploded due to COVID: What nurse researchers need to know

1 | INTRODUCTION

The COVID-19 pandemic compelled a surge of telemedicine activity to provide social distancing between health care providers and their patients, buoyed by a flurry of simultaneous federal and state telehealth policy changes to accommodate as many patients as possible. These policy adaptations included an increased number of telehealth services that could be reimbursed by Medicare, many state Medicaid plans, and even private insurers. The policy changes also relaxed Health Insurance Portability and Accountability Act (HIPAA) requirements for the technology platforms used, allowed for controlled medications to be prescribed remotely without first having an in-person examination, and made it easier for many types of health care professionals to practice across state lines under their current home-state licenses. These rapid policy updates were necessary, as some studies have indicated that up to an unprecedented 80% of all outpatient appointments were being conducted via telehealth during the peak periods of late March through May. Moreover, health systems, mental health centers, hospitals, and other health care organizations had to rapidly implement telehealth systems and protocols to meet the demand. As COVID-19 induced telehealth activity enters its 10th month, a few key questions have emerged. First, what have been the effects of this unprecedented pandemic and related policy changes on telehealth volume? Also, how has policy evolved and what policy accommodations will continue post-COVID? Will providers continue to leverage telehealth after the public health emergency ends? This short editorial opinions page provides some initial thoughts on these important questions.

2 | TELEHEALTH SURGE AND NATIONAL POLICY CHANGES

Telehealth visits went from very low volume nationally to huge numbers daily, or from "near to necessary" nearly overnight (Marcin, 2020). Our own health system at the University of Kansas Medical Center progressed from providing fewer than five telemedicine consults per week in February 2020, to over 1800 per day in April. By May 29th, 2020 the health system had surpassed 50,000 telehealth visits for a two-and-a-half-month period beginning in March. Similarly, The University of Virginia Health System witnessed a 9.000% increase in telehealth activity (Fairhealth Regional, 2020), and insurance companies reported comparable, massive increases in telehealth activity. Across all private insurers, telehealth claims lines increased 4.347% to 7.5% of all medical claim lines and increased 15.503% in the northeast part of the country. In addition, the Centers for Medicare and Medicaid Services (CMS) reported that pre-COVID, approximately 13,000 Medicare beneficiaries used telemedicine per week, compared to the last week of April in which 1.7 million beneficiaries received a telemedicine appointment (Health Affairs Blog, 2020). As a result the surging interest and volume, it is estimated that $250 billion of health care activity in the United States will be redirected to digital health care formats after the pandemic ends (Mondato, https://blog.mondato.com/telehealth).

Much of this activity was propelled by necessity but supported by policy accommodations from state and federal agencies that loosened restrictions on telemedicine and expanded eligible codes for reimbursement, as well as eligible locations and types of providers. For instance, the first known announcement on COVID-related telehealth policy changes came on March 17th, 2020 under the Coronavirus Preparedness and Response Supplemental Appropriations Act (cms.gov/newsroom). Perhaps most importantly in this update, CMS announced that it had temporarily eliminated the geographic restrictions for telehealth so patients would be covered by CMS regardless of whether they were in rural or urban areas. In addition, reimbursement for these services was to be covered by CMS if the originating site was the patient’s home—it did not have to be from one clinical setting to another at this time like it had been historically. CMS also planned to make payment on a broader range of telehealth services, would pay the same rate as a comparable in-person services, and allow telehealth in all health settings. All these changes were retroactive to March 6th, 2020 and would expire when the public health emergency ended.

At roughly the same time, several other telehealth accommodations were announced from other government agencies. The Health and Human Services (HHS) Office of Civil Rights, for example, announced that it would waive any potential penalties to providers who use non-HIPAA compliant video applications to provide telehealth services to patients (HHS, 2020). This meant that some common, consumer-oriented video programs like Facetime, Skype, Google Hangouts, and others could now be used for providing telehealth during the crisis. The guidance indicated that telehealth services that are provided in "good faith" and with all other available best practices would not be penalized. However, providers were instructed to notify patients of the potential for security risk if one of these non-healthcare video applications was utilized. While there were some apps that were...
Since the initial burst of policy accommodations in March and April, restricted, such as TikTok and other public-facing video communication tools, this rule made telehealth appointments significantly more accessible to patients. Similarly, the HHS Office of Inspector General reported that it would allow providers to waive cost-sharing for telehealth visits that were covered by federal healthcare programs. In addition, the Drug Enforcement Agency waived its normal requirement for an in-person examination before prescribing controlled substances via telehealth, as long as other federal and state laws were being met, the visit occurred through interactive video (instead of phone or other noninteractive medium), and that the medication was for a legitimate medical purpose (usdoj.gov, 2020).

In addition to these national policy updates, almost all states adjusted state Medicaid plans and licensing laws to allow for expanded interstate—interstate telemedicine activity. In Kansas, for instance, on March 22nd, 2020 the Governor announced that the Kansas Board of Healing Arts would not enforce Kansas licensure laws, thus allowing out-of-state providers to provide telemedicine in Kansas. The announcement also blocked enforcement of an in-person examination before prescribing or administering medication, and adapted Kansas Medicaid requirements for providing telehealth appointments and being reimbursed accordingly. These included the use of telephone or video for telehealth visits, telehealth in patients' homes, and enhanced telehealth services for many substance abuse disorders, home and community-based waiver programs, and person-centered planning services (Kansas.gov, 2020). Most other states made similar policy updates and announcements, with 47 states announcing some type of waiver for physician or other provider licensing by mid-April, according to the Federation of State Medical Boards (fsmb.org, 2020). Public information from private insurers about expanded policies or payment options for telehealth was much less available, although insurers in Kansas, when contacted, reported verbally that they were paying more telehealth claims than they were pre-COVID. As of this writing, no information was found that described the level of interstate telehealth activity although it is likely that some occurred especially nears states' borders where providers and patients live in close proximity but are just across the border of another state, such as in the Kansas City metropolitan area which traverses the Kansas–Missouri state line.

### 3 | POLICY AND ACTIVITY EVOLVES

Since the initial burst of policy accommodations in March and April, updates that further expanded the telehealth scope continued to be released throughout the summer, particularly by CMS. In mid-June, for instance, CMS enhanced the range of health professionals that could provide telehealth to any Medicare eligible providers, allowed hospitals to bill for home telehealth including an originating site fee and perhaps most importantly, codified a Coronavirus Aid, Relief, and Economic Security (CARES) Act requirement that Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC) could serve as distant sites. Distant sites are the locations that provide telehealth services to where the patient is located, called the originating site, and previously FQHCs and RHCs were prohibited from serving as distant sites. Another important aspect was that CMS would now accept special requests for telehealth reimbursement from practitioners outside of the normal rulemaking process to be added to the list of eligible services (cms.gov/ waivers, 2020). While it is not clear how many requests were submitted, this was a unique opportunity created by the pandemic. Around the same time, the Federal Communications Commission announced the $200 million COVID-19 Telehealth Program that would fund initial or enhanced broadband for healthcare organizations that needed more robust infrastructure for providing telehealth services. According to the most recent data, 539 healthcare organizations across the United States were awarded funding under this program, which may be another silver lining to the COVID pandemic as the foundation for much longer term telehealth success will be constructed (Department of Health and Human Services, 2020). While there were many other minor federal updates and many state-level updates too numerous to list here, overall, there was a great deal of coordination and flexibility demonstrated by agencies and policymakers nationwide. This unprecedented cooperation will likely have lasting effects on telehealth services and research even after some of the policy waivers expire.

### 4 | CURRENT POLICY STATUS AND LOOKING AHEAD

Currently, many of the COVID-related federal and state policies continue to be in effect, with an expiration date listed as the end of the public health emergency. At the federal level, to help determine the future direction of its telehealth policies, CMS has indicated it will be closely monitoring three specific aspects of telehealth activity during the pandemic including safety, payment rates, and fraud. Though it is unclear what exactly CMS has discovered about these issues in the last few months, a few hints have been provided. First, CMS released its 2021 Physician Fee schedule, which showed that many of the activity codes created during the pandemic would be eliminated for payment in 2021. Specifically, 74 of 83 codes created during COVID are slated for removal, accompanied by an explanation that CMS found “no likelihood of clinical benefit after the public health emergency ends.” However, CMS is proposing to add 13 new telehealth codes in 2021, for a net gain of 21 new telehealth services since the 2020 Physician Fee Schedule was released (CMS.gov, 2020). Perhaps the most substantial issue is the elimination of home telehealth visits for new patients, which will significantly reverse one of the hallmarks of both federal and state policy accommodations during this unprecedented time. Public comment on the proposed fee schedule was accepted until October 5, 2020, so it remains to be seen if any changes will be made to the proposal as a result of public input.

It is also unclear if the surge in telehealth activity will continue after the public health emergency ends. Anecdotal reports and a few recent articles suggest that post-COVID telehealth activity will fall somewhere between pre-COVID and peak-COVID rates (Fierce Healthcare, 2020; ASPE Issue Brief, 2020). In general, before COVID,
it is estimated that about 10% of all patient visits were conducted via telehealth and during COVID, levels as high as 80%–90% were reported. In one survey of 300 practitioners, oncologists, specialists, and primary care providers, conducted between April 17th and 22nd, only 9% of their patient interaction was via telehealth before the pandemic, this reached about 51% during the pandemic period and is expected to be around 21% after the pandemic ends (Bashshur et al., 2020). Recent experience indicated that during late summer many clinics and hospitals started to reopen. Telehealth activity levels were reportedly starting to drop as providers, staff, and patients became more comfortable with virus mitigation strategies. Despite this apparent reduction in telehealth activity in some settings, it is unlikely that telehealth appointments long-term will fall to pre-COVID levels as patients and providers with a newfound awareness and interest in telehealth drive future telehealth volume.

5 | TELEHEALTH RESEARCH DURING AND POST-COVID

With this unprecedented and unexpected telehealth volume, research related to telehealth during the pandemic has ballooned as has research related to other aspects of health care during this crisis. The National Institutes of Health (2020) have led the charge by soliciting research projects on the need for safe telehealth interactions, COVID home managed treatment, and post-COVID impact. For example, the call for grant submissions on the topic of Digital (which include telehealth) Healthcare Interventions to Address the Secondary Health Effects Related to Social, Behavioral, and Economic Impact of COVID-19 (PAR-20-243, 2020).

Of the many positive features of telehealth care, it has been clear in our 15 years of telehealth experience, that being able to “see” the patient in their home environment and to have the ability to listen to their concerns is key. Listening to patients and their families is fundamental to providing care or to conducting research using telehealth. While it is unfortunate that COVID made telehealth a necessity, it is fortunate that the resulting telehealth activity has provided patients, providers, and researchers alike, an opportunity to better utilize and understand these services for future generations.

CONFLICT OF INTERESTS
The authors declare that there are no conflict of interests.

DATA AVAILABILITY STATEMENT
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