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Paying for Telemedicine After the Pandemic

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One of the major positive changes in care delivery during the COVID-19 pandemic is the surge in telemedicine use. Because telemedicine eliminates the risk of viral transmission during travel and in the clinical setting, it has been a valuable tool for maintaining patient's access to care for both COVID-related and non-COVID-19 related health issues.

In Australia, Canada, and the United States there were sudden and substantial increase in the use of telemedicine during the pandemic. At its peak in April, telemedicine was responsible for 38%, 42%, and 77% of *all* ambulatory visits among Australia's Medicare program,[1] the commercially insured in United States,[2] and in Ontario, Canada, respectively. Since that peak there has been a decline in telemedicine use across the three nations, but use remains substantially higher than pre-pandemic levels. Most telemedicine visits were via telephone, making up 90% of the telemedicine visits in Canada and Australia.

The surge in telemedicine was facilitated in part by changes in government policy that temporarily expanded which telemedicine services could be reimbursed. But now countries face the dilemma of what to do after the pandemic. Both patients and clinicians are enthusiastic about the convenience and ability of telemedicine to improve access. How then can nations build upon this enthusiasm, without disadvantaging or harming patients, or driving an unsustainable increase in healthcare spending?

Temporary changes in telemedicine policy

Prior to the pandemic, telemedicine in the Australia, Canada, and the United States was largely used by patients in rural and remote locations for videoconference visits with specialists. In mid-March a similar set of changes were implemented. In Australia, telemedicine coverage was expanded to telephone and videoconference telemedicine visits with all clinicians for all citizens.[1] In Ontario and other Canadian provinces, temporary codes were added that paid for telemedicine visits, either via telephone or videoconference, for all patients at the same rate as in-person visits.[3] In the United States Medicare program, the federal insurance program for older and disabled adults, coverage was expanded to

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telephone and videoconference visits for all patients and the first time could be provided to patients in their homes.[4] This change in Medicare was largely followed by other insurers in the United States.

What happens when the pandemic slows and hopefully finally ends? There is uncertainty in each country about how long the temporary payment expansions will continue and what telemedicine policies will look like post-pandemic. Although the pandemic may last for some time, the decisions about post-pandemic plans have some urgency. After the initial surge of telemedicine uptake, it appears many clinicians have abandoned telemedicine, in part because of the uncertainty around telemedicine's financial sustainability.

Issues facing policymakers

In determining telemedicine policy after the pandemic, policymakers will have to strike a difficult balance. The potential benefits are clear. The convenience of telemedicine can improve access to care for all patients and, in particular, underserved populations such as those in rural communities. This convenience translates into lower no-show rates and, for some conditions, it may improve outcomes.[4] There are also the economic benefits for patients of less travel time and time off work.

But there are also concerns. While randomized trials have supported the idea that telemedicine is of equal quality for some conditions, videoconference and telephone visits are limited by the inability to complete a full physical examination and perform ancillary testing. For example, it is impossible to reliably diagnose an infant with an ear infection without examining the ear - and, not surprisingly, telemedicine visits for ear infection without such imaging result in greater use of antibiotics.[5] The potential for unnecessary overuse of care and increased fraudulent ordering of diagnostic tests and equipment[8] have been other barriers to telemedicine expansion. One example of overuse is that clinicians may schedule frequent but shorter phone visits that may not improve outcomes but do increase government spending. There is also the concern telemedicine could potentially worsen disparities if it is preferentially used by wealthier urban patients, rather than rural and poorer patients who are less likely to have access to a computer, smart phone, or high-speed internet.

How to move forward?

The likely path forward is to expand telemedicine coverage beyond what was available prior to the pandemic, but not maintain the current broad expansion of telemedicine. But how can this compromise be achieved?

The decision should be based on value. Like all medical technologies, telemedicine will typically increase spending. Under a value framework, the question is how much value (improvements in care outcomes or access) is observed and at what cost. The goal is to encourage higher-value applications of telemedicine and discourage lower-value applications.

Policymakers can use several strategies to encourage high-value care. Coverage can be limited to certain patient populations, telemedicine visit modalities, or to certain conditions. Before the pandemic, limitations across all these dimensions were observed, such as limiting telemedicine visits to rural residents, to videoconference visits, for treatment of a potential stroke or opioid use disorder.[8] Underlying these coverage choices was the assumption that the resulting telemedicine visits will be of higher value. Ideally any coverage limitation would be based on robust evidence. However, in many cases there is no evidence, which means the decision may be based upon estimated clinical use.

Another question is whether telephone visits should be reimbursed by insurance. From a quality and spending perspective, there is the concern that the lack of visual cues during a telephone visit leads to inferior care in some clinical scenarios and that telephone visits are more likely to be overused. However, telephone visits are likely reasonable for many situations and from an equity perspective, telephone visits are important for patients who cannot have a videoconference visit.

A key area of debate is the payment for telemedicine visits. This debate is being driven by two different perspectives. One approach for determining payment is to base reimbursement on the time and resources required for a visit. Under this approach telephone visits would be paid substantively less because phone visits do not require the purchase of any new technology and require lower overhead. The second approach to payment is based on the idea that clinicians will choose between telemedicine and in-person visit based on their relative reimbursement. So even if a telephone visit requires lower less resources, telemedicine proponents might argue that these visits should be priced at the same amount so that physicians do not always choose in-person visits. The counterargument is that governments should pay less for telemedicine visits to deter overuse. Policymakers will need to balance both perspectives.

Along with the short-term question of how to pay for videoconference and telephone visits after the pandemic there is also the longer-term issues on how to pay for the many other forms of telehealth including remote monitoring and asynchronous portal messages. Paying for each interaction between patient and clinicians becomes much more complex. This has accelerated the debate on moving to population-based payment models for clinicians.

Prior to the pandemic, routine use of telemedicine seemed a long way away and much of the policy debate focused on how to increase uptake. The pandemic has driven a sudden and substantial increase in telemedicine in many countries. Each country will have to decide its own path forward on how to build off this sudden change and encourage high-value telemedicine care for their citizens moving forward.

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