Telehealth: A Crucial Solution in Uncertain Times
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A Deloitte 2018 Survey of U.S. Physicians revealed that, while 90% of the doctors surveyed saw value in virtual care, only 14% had adopted these tools into their practice. The physicians studied reported that they saw the proof that telemedicine is patient-centric and had many benefits, including improvements in patient access to medical care, patient satisfaction, and connection between caregivers and patients.

The onset of the COVID-19 pandemic has compelled the practice of medicine to incorporate the use of technology at a previously unimaginable rate. Until now, the healthcare community was tiptoeing into the telehealth delivery mindset, with reluctance to commit. Thoughts were that remote access would first be for physicians and other providers with patients who lacked access to healthcare due to rural hospital closures, areas with a shortage of clinical providers, and as a response to the increasing costs of care delivery.

Of those surveyed, 18% said they would add a telehealth service line in the next two years. However, of the doctors currently that had access to telemedicine tools, only one-third actually used them.¹
The picture has changed drastically from 2018 to 2020. The adoption of conducting telehealth visits is expedient in many instances and pragmatic considering the COVID-19 pandemic. The Centers for Medicare & Medicaid Services (CMS) has broadened access to Medicare telehealth services so that beneficiaries can receive a wider range of services from their doctors without having to travel to a healthcare facility.
The following are the key takeaways from a March 17, 2020, CMS Press Release:

- Effective for services starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to patients in broader circumstances.

- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.

- Starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.

- While they must generally travel to or be located in certain types of originating sites, such as a physician’s office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020, and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and in their home.

- The Medicare coinsurance and deductible would generally apply to these services. However, the HHS Office of Inspector General (OIG) is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.

- To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.
In a rush to adapt to the use of telemedicine, it is a mistake to assume that everyone is at the same level in their understanding. Not everyone is starting from the same yard line or viewing the opportunities through the same lenses. In this paper, we will discuss telehealth delivery and technology from the viewpoints of the providers, payers, and investors.
Views regarding telehealth from the provider side
Generally, we think of telehealth/telemedicine in three components:

- Commodity-based services (e.g., sniffles treatments direct to consumer)
- Management of chronic conditions
- Leveraging geographic limitations of various types of specialists (lack of access, especially in rural areas)

These components still apply, now at a pandemic level. We see rapid expansion and increased competition across the board in these areas primarily generated from the COVID-19 pandemic. Yet, in many hospitals and health systems, there is far less telemedicine technology in place than is needed. Many entities have delayed implementation because of the complexities around billing and level of reimbursement. Physicians who were reluctant to enter the telehealth realm had good cause. The challenges regarding reimbursement—billing, compliance, and liability—are a well-documented complication. The loosened restrictions issued by CMS will alleviate some of the provider-voiced concerns over the provision of telehealth during the COVID-19 emergency. The extent to which these loosened restrictions remain post COVID-19 is an open question.
Today, we need telemedicine to provide as little contact between health professionals and virus-carriers as possible, while still delivering care. Telemedicine is how hospitals are unclogging waiting rooms, triaging patients, monitoring the less sick, and supporting the fight against the coronavirus disease by treating those with other maladies from afar.

Some entities are developing internal platforms for various specialties to deliver professional services via telemedicine. Among those specialties is the delivery of psychiatric care, which is being tested nationally for the possibility of providing care across state lines.

A significant area of concern is to be sure that participating provider agreements (PPAs) are fair and reasonable. Some contracts have conditions that may not apply, are not relevant, and are unreasonable. In working with Medicare and Medicaid, the PPAs must have data-capturing conditions and reporting conditions to be compliant. In many instances, the private insurers will also follow such protocols, which is a positive factor. That infrastructure will be necessary to operate and be subject to PPAs.
Views regarding telehealth from the payer side
Like the previous comments, increasing acceptance for reimbursement of services, particularly in the commodity-based services component, noted above, is increasing. Not all states have coverage parity, but most do. The COVID-19 crisis will quickly accelerate this uniformity. The process will be government-lead, with the private insurers following swiftly. For example, from Medicaid’s view, although some states have requirements for coverage and payments, the funds and reimbursement are not reflected in state budgets. For COVID-19, Medicare and many other payers are now covering visits that they previously did not cover until as recently as a few weeks ago.

More doctors providing telemedicine during the pandemic means that more doctors are subject to the laws of telemedicine.

These laws come from the state the provider is in, and the state in which they are providing teleservices. A handful of states have passed payment parity laws, which require payers to reimburse some telehealth services at the same rates as in-person visits. The relaxation of some of the reimbursement hurdles announced by CMS on March 17, 2020, should have a lasting impact on the adoption of telehealth and the growth of the industry.

Several of the payers, including Medicare and Medicaid, have previously contracted directly with the platform providers, so they are going straight to the vendors, not the medical providers. The vendors will then contract with the providers who want to be in their network.
Views regarding telehealth from the aggregated provider side
The margins in telemedicine visits are modest. The consumers pay $60 to $100 per visit. This can sometimes be at least partially mitigated through efficiency of patient throughput. The provider is not moving from room to room and is not interrupted by staff with questions. The payers go directly to turnkey platforms, so they do not see the advantage of the typical collaborations. We believe a large provider network approach for payers with a global contract for such services as being workable. Turnkey platforms will typically use providers who are retired or younger employed physicians looking for side or “moonlight” income. These networks are a hodgepodge of providers (including APPs) who have previously been interested in extra income. COVID-19 may well change this dynamic, with a significant rise in the numbers of full-time telehealth providers.
Overall, the platform works similarly to Uber. A request for a consult comes in; then, the app sends out a notice to the providers in their network, letting them know a patient is ready to be seen. When they accept, the visit will start, or the provider will contact the patient. One of our employees recently had such a telemedicine visit. It was smooth and convenient, without hassle. The COVID-19 situation will increase the volume of similar telehealth calls. Therefore, organizations with large provider networks should approach the payers to become one of their national providers for telemedicine services.
Views regarding telehealth from the investor side
The rise in the adoption of telehealth Investors has piqued the attention of investors. **Telehealth investments in venture funding deals for U.S.-based digital health startups that raise more than $2 million have grown more than tenfold between 2011 and 2019,** according to Rock Health, a digital health investment firm. In addition to publicly traded telemedicine and virtual health companies, smaller, private telehealth companies have the potential to go public.³
S&P Global Market Intelligence reports that some large tech companies are increasing their presence in digital health, although they are keeping their plans under wraps. Major telecommunications companies, such as AT&T, Inc., and Verizon Communications, Inc., are partnering with hospitals and healthcare providers to develop and test 5G use cases for the healthcare industry.

Although there are ongoing regulatory hurdles, healthcare and industry representatives expect that telemedicine can change the delivery of modern medicine in the U.S.
Views regarding telehealth from the technology side
Telemedicine software is used to deliver clinical services to the patient from any remote location. The available options for software technology are wide-ranging, from full telemedicine applications to simple practice-level cloud platforms. Some of the software platforms are free and open source, while others have a license that restricts users from modifying the source code.

Three scenarios appear to exist:

- **Turnkey platforms** where the vendor offers the technology and providers. These vendors, typically, are going direct to consumers. For example, a medical practice can sign up and join their network with an arrangement to split their fee with the vendor. This agreement is suitable for physicians who seek some passive income without the investment of extensive efforts. A provider can sign up and wait for the notification by telephone to conduct the visit. The average fee is $60 to $100. The provider generally gets 50%, but the percentage can be negotiable.

- **Platforms that supply the technology directly to medical groups and hospitals and other providers who want to deliver telehealth services to their patients.** There are several platforms available from which to choose. They range from free to a per-visit fee pricing.

- **Health systems that attempt to build their platforms.** We expect the instance of systems building their platform will escalate during the COVID-19 crisis and afterward.
For example, the feature of having a complete medication list when prescribing a new drug is extremely vital to patient safety to avoid a drug-to-drug interaction. Most EHRs would quickly alert the provider with a pop-up warning. For this alert to occur during the telemedicine visit, the provider would have to be charting in the EHRs while also trying to navigate his or her phone, the video conference device, and the telemedicine platform. There is also the element of scheduling the visit, capturing the charge, and billing for the service. These functions would be in the practice management system or another platform or module that is outside of the telemedicine platform.

Telemedicine and Interoperability into EHRs

A common challenge of many telemedicine platforms is their lack of interoperability with the various EHRs on the market, forcing both the provider and patient to co-exist in two systems, and creating many provider-patient satisfaction challenges. More concerning is the risk of treating a patient with an incomplete record or without all the alerts providers have become accustomed to receiving when charting in their EHRs.
An easy, yet sometimes daunting, task would be to integrate these platforms. We say daunting, because most people think integration is complicated and expensive when in most cases it is not. Having integrated several EHRs to telemedicine platforms, we generally link to the export and import utilities and standards that already exist. Also, there are standards, such as the continuity of care record (CCR), that are universally accepted as a standard for interoperability. We strongly recommend integration for the following reasons:

1. **MAINTAINING PATIENT SAFETY AND COMPLIANCE**
2. **CREATING A COMPLETE MEDICAL RECORD**
3. **IMPROVING THE PROVIDER-PATIENT EXPERIENCE**
4. **ENSURING PROPER CAPTURING OF CHARGES & BILLING CODES**
5. **REPORTING AND AUDITING**
6. **OPTIMIZING PROVIDER PRODUCTIVITY AND EASE OF USE**
Conclusion
Providers, payers, and clinically integrated and provider networks must get on the fast track in establishing their telehealth capabilities in an era of uncertainty. Each perspective addressed in this paper, e.g., physician, hospital, provider network, or investor, has a part to play in adoption, application, and technology preparation and arrangements. The unanticipated demands of the COVID-19 pandemic have moved any remaining reticence over the edge. The broadening of services offered through telehealth is charting a path to deliver vital medical services in a period of overwhelming shortages of professional consultation.
Sources


For further information about Coker Group, and how we could be of assistance, please call 1.800.345.5829 or visit cokergroup.com