

The Impact of Telehealth on Healthcare Valuation

By *Richard Romero, CVA, ABV, CHFP, PAHM*

The COVID-19 outbreak resulted in the need to practice social distancing, remain in our homes, and apply technology in new ways to accomplish daily life and work tasks and provide patient care. Remotely caring for patients is not new; telehealth has been prevalent in some aspects of healthcare for years. According to the American Hospital Association, prior to COVID-19, “76 percent of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology.”¹ In the American Health Insurance Plan 2019 Virtual Care Survey, 94 percent of commercial plans, 92 percent of Medicare Advantage Plans, and 62 percent of Medicaid plans offered virtual care.² However, with the need for social distancing, the use of telehealth was significantly expanded to provide patient care remotely to help protect both patients and providers from infection.

This most recent expansion of telehealth, to a degree of use previously not allowed under Medicare, can be attributed to authorization of its use in new ways during the declared public health emergency (PHE). And while most believe that the telehealth horse has not completely left the barn, the reigns may have been permanently loosened. To understand some of the possible impacts of these temporary policy changes, one needs to understand some key definitions, uses of telehealth, temporary waivers issued by the Centers for Medicare and Medicaid Services (CMS) permitting the use of telehealth in new ways, and the impact of these changes on healthcare operations. For purposes of valuation, a key underlying concept is that change brings risk, and risk impacts the value of healthcare provider business enterprises.

What Is Telehealth?

Answering this question can be difficult because answers vary considerably based on one’s perspective. In one sense, the answer describes the nature of the technology used to provide the service. The American Telemedicine Association (ATA) provides the following definitions:³

- **Live videoconferencing (synchronous):** The delivery of a live, interactive consultation between primary care and specialist health services. This may involve a primary care or allied health professional providing a consultation with a patient, or a specialist assisting the primary care physician in rendering a diagnosis.
- **Store and forward (asynchronous):** The use of store and forward transmission of diagnostic images, vital signs, and/or video clips along with patient data for later review that enables a primary care or allied health professional providing a consultation to render a diagnosis.
- **Remote patient monitoring:** Including home telehealth, uses devices to remotely collect and send data to a home health agency or a remote diagnostic testing facility for interpretation. Such applications might include a specific vital sign, such as blood glucose or heart ECG, or a variety of indicators for homebound consumers. Such services can be used to supplement the use of visiting nurses.
- **Mobile health:** Consumer medical and health information includes the use of the internet and wireless devices for consumers to obtain specialized health information and online discussion groups to provide peer-to-peer support.

Another way to answer the question is to consider the reasons telehealth services are needed, e.g., to provide commodity-level services, manage conditions, or leverage the reach of clinical specialists to overcome geographic limitations.

1 “Fact Sheet: Telehealth,” American Hospital Association (February 2019), <https://www.aha.org/system/files/2019-02/fact-sheet-telehealth-2-4-19.pdf>.

2 “Virtual care takes center stage for health plans,” Teladoc Health, Inc. (2019), https://www.ahip.org/wp-content/uploads/VirtualCareTakesCenterStageForHealthPlans_forAHIP.pdf.

3 The website of the American Telemedicine Association, “Telehealth Basics,” <https://www.americantelemed.org/resource/why-telemedicine/>.



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Commodity-Level Services

Telehealth is widely used in the direct-to-consumer space. These visits serve as a direct alternative to in-person visits, providing greater convenience for patients. The clinical complexity of the issue may not be significant in many cases. Think of the sniffles or getting a prescription refilled. Within the realm of professional medical services, these visits can be described as a commodity-level service, with patients willing to have the visit with any available quality provider. This concept is also seen in remote reads of diagnostic tests. An individual provider reading diagnostic tests may be part of a group or groups of providers who review diagnostic tests remotely without directly interacting with patients. If all providers perform a quality review of the diagnostic test, the service can be viewed by consumers at a commodity level with quality providers viewed as substitutes.

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Management of Chronic Conditions

The current and potential use of telehealth to care for patients with chronic conditions is vast. The use of remote physiological monitoring or remote patient monitoring allows providers to assess information obtained from patients and to provide and prescribe appropriate care. For example, during the COVID-19 crisis, one hospital sent patients home with pulse oximeters, which allowed providers to assess oxygen saturation without patients being physically present in the hospital. In other cases, through remote patient monitoring—such as daily reporting of weight and answers to a series of questions—providers were able to care for transplant patients in their homes, avoiding the time, expense, and inconvenience associated with travel.

Overcoming Geographic Limitations

Telehealth has been used to leverage clinical expertise across distance for years. A well-known example is its use in the diagnosis of strokes. Injection of a tissue plasminogen activator (TPA) is considered the “gold standard for treatment of ischemic stroke.”⁴ However, time is of the essence as there is a recognized correlation between patient outcomes and the amount of time elapsed between the stroke and administration of the injection. It is not uncommon for hospitals in rural markets to be unable to staff a neurologist. In these circumstances, telehealth is often used to provide care and save lives. Other examples include intensive care unit (ICU) “bunkers,” where patients from multiple hospitals are monitored 24-7 using video screens in a remote location, and the use of telehealth to obtain electronic consults from other provider specialties, such as pediatric neurology or pediatric genetics. This concept is being expanded as providers work to develop virtual centers of excellence.

The Importance of Definitions

There is no universal definition of telemedicine or telehealth. Several terms describe the use of technology to care for patients remotely, such as telemedicine, telehealth, virtual care, and digital health. However, the most important definitions are those used by payers to describe covered and reimbursed services.⁵ These definitions vary among payer types, with Medicare, Medicaid (which also varies from state to state), and private payers each having different coverage and reimbursement rules.⁶ Understanding these definitions and their limitations is critical to understanding reimbursement and, therefore, telehealth’s impact on the value of entities that perform (or do not perform) these services.

Approved Telehealth List

Medicare covers a defined list of telehealth services if certain requirements are met.⁷ For example, the Medicare beneficiary generally must receive services (1) in a county located outside a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA), (2) at an approved site (e.g., a hospital, physician’s office, rural health clinic, skilled nursing facility), and (3) from an eligible practitioner using

4 Mayo Clinic, s.v. “Stroke,” accessed July 1, 2020, <https://www.mayoclinic.org/diseases-conditions/stroke/diagnosis-treatment/drc-20350119>.

5 The Center for Connected Health Policy maintains updated data about coverage and reimbursement rules for each state.

6 This article will not provide a list of these definitions, which are available online.

7 See Medicare Physician Fee Schedule, <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched>.

approved technology.⁸ In industry parlance, these location limitations are referred to as “1834(m)” restrictions.⁹

Reimbursement

Under Medicare regulations, there is a facility fee payment to the originating site and a payment for professional services performed by the provider at that site. Under Medicare Part B, the payment amount to the originating site is generally the lesser of 80 percent of the actual charge or 80 percent of the originating site facility fee.¹⁰ The originating site fee amount is updated each year in the Medicare Physician Fee Schedule. For some sites, such as the patient’s home, an originating site payment would not be applicable. For the professional service, the payment rate is consistent with what would have been earned had the service been performed at a facility rather than the distant site.

Adding to the Telehealth Approved List

The Medicare telehealth approved list is comprised of codes from the Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS). Each year, the CMS reviews submissions for additional codes to be added to the approved list. To be added, a code must meet the requirements of one of two approval categories:

- Category I: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services. In reviewing these requests, CMS looks for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. CMS also looks for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.¹¹
- Category II: Services that are not similar to those on the current list of telehealth services. Under this category, CMS assesses whether the CPT code accurately describes a service when it is provided via telehealth and whether the patient receives a demonstrated clinical benefit from the use of telehealth. To assess the clinical benefit, CMS

requires clinical studies and published, peer-reviewed articles for its review.¹²

Examples of clinical benefit include:

- Ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services;
- Treatment option for a patient population without access to clinically appropriate in-person treatment options;
- Reduced rate of complications;
- Decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process);
- Decreased number of future hospitalizations or physician visits;
- More rapid beneficial resolution of the disease process treatment;
- Decreased pain, bleeding, or other quantifiable symptoms; and
- Reduced recovery time.

As evidenced from the requirements of these approval categories, additions to the covered telehealth list under Category II require significant effort. However, CMS used its authority to temporarily authorize codes under Category II, significantly expanding coverage of telehealth services during the PHE.

Remote Care That Is Not Telehealth

Medicare also covers a variety of services that might be referred to as telehealth but are not defined as telehealth under Medicare rules. These codes include online digital evaluation and management services, remote patient monitoring codes, and online digital assessments.¹³ Some of these codes were approved within the last two years and prior to the PHE. It is important to note that, because these services are not defined as telehealth under Medicare regulations, they are not affected by the 1834(m) restrictions. CMS clearly recognized the need to support electronic care well before the PHE.

Expansion of Telehealth Services Due to COVID-19

Even before the onset of COVID-19, the use of telehealth was in a growth phase. Industry surveys suggested that physicians

⁸ See 42 CFR § 410.78.

⁹ See Social Security Act § 1834(m), 42 U.S.C. § 1395m(m).

¹⁰ There are various exceptions, including certain services performed at critical access hospitals.

¹¹ 84 Fed. Reg. 62627 (November 15, 2019).

¹² 84 Fed. Reg. 62627–2 (November 15, 2019).

¹³ Note: Online digital assessments can be performed by a nonphysician healthcare professional.

were increasingly willing to use telehealth and that more than half expected to use it frequently by 2022.¹⁴ However, due to COVID-19, telehealth became a necessity in many cases. As described by CMS:

In this extraordinary circumstance, we recognize that public exposure greatly increases the overall risk to public health. We believe that this increased risk produces an immediate change, not only in the circumstances under which services can safely occur, but also

results in an immediate change to the business relationships between providers, suppliers, and practitioners. By increasing access to services delivered using telecommunications technology, increasing access to tests in a patient’s home...will provide the necessary flexibility for Medicare beneficiaries to be able to receive medically necessary services without jeopardizing their health or the health of those who are providing those services, while minimizing the overall risk to public health.¹⁵

14 “Telehealth Index: 2019 Physician Survey,” American Well, <https://static.americanwell.com/app/uploads/2019/04/American-Well-Telehealth-Index-2019-Physician-Survey.pdf>.

15 Interim Final Rule CMS-1744-IFC, Centers for Medicare and Medicaid Services (March 30, 2020), 10, <https://www.cms.gov/files/document/covid-final-ifc.pdf>.

Table 1: More than 200 CPT Codes Added or Approved for Audio-Only Service

CPT Code Category	Number of CPT Codes Impacted	Category Example
Radiation Oncology	1	77427—Radiation treatment management
Behavioral Health	24	96127—Brief emotional/behavioral assessment
End Stage Renal Disease (ESRD)	5	90962—ESRD related services monthly, with face-to-face visit
Speech, Occupational, Physical Therapy	40	92507—Treatment of speech, language, voice, communication and/or auditory processing disorder
Hospital Observation and Inpatient Care	15	99217—Observation care discharge day management
Emergency Department Services	5	99281—ED visits for the evaluation and management of a patient
Critical Care	2	99291—Critical care, evaluation and management, first 30-74 minutes
Nursing Facility Care	10	99304—Initial nursing facility care per day, evaluation and management
Home and Domiciliary Care	18	99341—Home visit for the evaluation and management of a new patient
Audio Only Evaluation and Management	3	99441—Telephone evaluation and management
Inpatient Neonatal and Pediatric Critical Care	7	99468—Initial inpatient neonatal critical care, per day
Intensive Care Services	4	99478—Subsequent intensive care, per day, low birth weight infant
Additional Audio Only Designated Codes	67	97802—Medical nutrition therapy, face-to-face
Total	201	

As a result of these concerns, for the duration of the PHE, CMS added several codes to the list of approved Medicare telehealth services, eliminated frequency limitations on how often certain codes can be billed, removed certain requirements for services provided via telehealth, provided guidance on payment rules for certain services, and provided guidance regarding the use of certain technologies.

In response to COVID-19, as of April 30, 2020, CMS added over 200 CPT codes to the telehealth list, including a number of services that may be provided via audio-only visits.¹⁶ Many of these additions were added to the telehealth list on a Category II basis. Added codes covered services for emergency department visits, initial and subsequent observation and discharge, initial hospital care and hospital discharge, initial nursing facility visits and discharge, critical care services, rest home or custodial care services, home visits, inpatient neonatal and pediatric critical care, initial and continuing intensive care services, care planning for patients with cognitive impairment, group psychotherapy, end-stage renal disease, psychological and neuropsychological testing, therapy services, and radiation treatment management services. As evidenced by a review of these changes, patient care was changed at a variety of locations, including hospitals, physician practices, skilled nursing facilities, and radiation treatment centers. Table 1 summarizes these changes.¹⁷

COVID-19 Reimbursement

CMS carefully considered reimbursement for telehealth services during the PHE. A provider is reimbursed the amount normally allowed had the provider seen the patient in person. If the visit would have occurred in a provider-based facility, the provider receives the facility rate. If the provider would have seen the patient in the provider's office, the higher non-facility rate is allowed. Prior to COVID-19, physicians providing telehealth services were generally compensated at the facility rate.

Because reimbursement rates are a function of costs, CMS anticipates that resources during the PHE will remain consistent: "We expect that physician offices will continue to employ nursing staff to engage with patients during telehealth visits or to coordinate pre- or post-visit care, regardless of whether or not the visit takes place in person."¹⁸ As telehealth grows, the composition of underlying resources used to provide services will change. As a result, the costs of conducting telehealth visits will likely diverge from the amounts for in-person visits.

Telehealth Expansion's Impact on Operations

In response to COVID-19, CMS made several temporary changes that affect where telehealth services can be provided, what can be billed, how and when providers

In response to COVID-19, CMS added over 200 CPT codes to the telehealth list, including a number of services that may be provided via audio-only visits.

¹⁶ Because many patients lack access to the interactive audio-video technology ordinarily required for Medicare-covered telehealth services (or prefer not to use it), CMS expanded the list of services it will cover on an audio-only (telephone) basis.

¹⁷ On August 3, 2020, President Trump issued an executive order calling for the expansion of telehealth services to be made permanent. This includes "the services, reporting, staffing, and supervision flexibilities offered to Medicare providers in rural areas." The same day, CMS issued the 2021 proposed Medicare Physician Fee Schedule. The proposed rule suggests allowance of direct supervision to be performed via telehealth, change in frequency limitations for telehealth services for nursing homes and hospital inpatient units, increase in provider types that can bill certain codes, and the addition of nine codes as telehealth services under Category I procedures.

¹⁸ CMS Interim Final Rule, 14.

may bill for these services, and how much providers will be paid for them. In light of these changes, it is imperative for valuation analysts to understand their potential impact on cash flow.

By adding codes for initial and subsequent care periods for critical care (often performed in ICUs)¹⁹ and radiation treatment management, CMS allowed services previously required to be performed in person to be performed via telehealth. CMS stated that it previously declined to add these codes to the approved list, citing concerns regarding “patient acuity and the feasibility of fulfilling all of the required elements of a service via communication technology.”²⁰ However, given the risk of exposure and potential limitations on access to care, these codes were added to the list of services allowed to be provided remotely.

If an entity provided telehealth services prior to COVID-19, the valuator should consider how patient workflows, and resulting resource needs, changed during the PHE.

CMS also waived certain frequency limitations (i.e., the number of covered visits permitted over a certain number of days) that otherwise applied to certain telehealth services. These limitations were removed because CMS does “not believe these frequency limitations are appropriate or necessary”²¹ during the PHE.

For certain services to be performed by a nonphysician, a credentialed physician is required to provide supervision (i.e., the physician must be available to consult or, in some cases, be physically present). During the PHE, CMS allowed certain physician supervision requirements to be satisfied using telehealth, a significant change from historical requirements. Will CMS allow this to continue after the PHE?

CMS also made changes applicable to specific provider types: A new payment rate was developed for telehealth services at Rural Health Clinics and Federally Qualified Health Centers due to COVID-19. CMS issued specific instructions regarding which codes and modifiers to bill and

procedures for submitting claims, including an instruction to hold the submission of claims until July 1, 2020, under certain circumstances.

Potential Future Impact

As a result of COVID-19, there has been a significant increase in the number of providers performing telehealth services across the health care spectrum.²² In the first quarter of 2020, Teladoc added more than six million new paid members who generated more than two million patient visits. Notably, 60 percent of those visits came from first-time virtual care users.²³ As we move to our collective new normal, there are several telehealth factors valuers should consider when performing healthcare valuation services. We often look to the past as a reference to project future operations. However, one can argue that not a single health care entity will return to operating in the same manner as it did before COVID-19. So how do we develop our telehealth “prophesy as to the future?”²⁴

Understanding an Entity’s Telehealth Foundation

To begin, valuers should develop an understanding of how telehealth was employed by an entity prior to COVID-19. Interview management regarding which specialties employed the technology, how it was used, where it was used, and the level of reimbursement obtained for these services. The valuator should understand state laws regarding coverage and payment parity.²⁵ If the entity has a director of telehealth, or a person with a similar role, the valuator should interview that professional when reviewing telehealth services. The valuator should understand the willingness of the entity to engage in telehealth prior to the PHE, major challenges the entity faced in deploying those services, the influence of physician and C-suite telehealth champions, and clinical outcomes of services. Patient satisfaction should also be reviewed. Keep in mind that even if a physician is willing to provide these services, additional specific training on how to conduct an effective telehealth visit may be required.²⁶

The Experience-Risk Connection

If an entity provided telehealth services prior to COVID-19, the valuator should consider how patient workflows, and resulting resource needs, changed during the PHE. Some of the current

22 A nonscientific survey conducted by the Coker Group revealed that 65 percent of respondents began providing telemedicine services as a direct result of COVID-19.

23 “Virtual Care During and After COVID-19” (online presentation, AHIP, May 11, 2020).

24 IRS Revenue Ruling 59-60.

25 Almost all states require insurers to pay for telemedicine services.

However, not all states have payment parity laws, which require reimbursement for telemedicine services to be equal to in-person services.

26 Notably, specific training on how to conduct a telemedicine visit has been included in various graduate medical education programs for years.

19 For those unfamiliar with this aspect of healthcare, a key service performed in ICUs is ventilator management.

20 CMS Interim Final Rule, 41.

21 CMS Interim Final Rule, 41.

rules are temporary and not all of them will be continued, so when assessing volume, production, and revenue, the valuator should carefully consider the role telehealth is likely to play for the entity if certain restrictions are put back in place. However, it is reasonable to expect a permanent shift, at least to some degree, from in-person to video or audio visits, and a permanent increase in remote patient monitoring in many cases.

If an entity has prior telehealth experience, risks related to post-PHE telehealth services are reduced. These entities have experience with issues of reimbursement, provider staffing, support staff scheduling, specific training of personnel for the provision of services, and the general move from in-person to electronic communications. In some markets, it can also mean an opportunity to gain market share from competitors. If an entity is not providing telehealth services, the valuator should consider what portion of services could be provided by competitors from legal, patient care, and reputational perspectives. Patients receiving services before the PHE may become a target for competitors that provide services remotely.

Another potential risk involves the delivery of telehealth services by many providers via nontraditional platforms—such as Zoom, Skype, and Facetime—under temporary waiver authority. Regulators were aware that these platforms may not be HIPAA compliant, but felt the PHE provided sufficient justification to allow their use. Other providers have taken advantage of more traditional telehealth technologies offered on a free or reduced-cost basis. Providers should ensure that the technology they use during the PHE is suitable for their planned delivery of telehealth services going forward.

Three additional risk areas to consider, for both historic and new telehealth users, are cybersecurity, integration with electronic health records, and addition of telehealth to an entity's formal compliance program. A valuator should (1) understand the technology used to provide telehealth services and whether it meets cybersecurity requirements, (2) review an entity's ability to integrate the technology into its electronic health record system, and (3) determine whether an entity has incorporated telehealth into its formal compliance program. It is expected that the regulatory environment will return to more stringent enforcement standards post-PHE.

Longer-Term Impact

As we adapt to the new normal to come, telehealth will be a foundational modality of healthcare services. A clear understanding of what can be billed and how much reimbursement will be received is essential in forecasting. However, given the temporary nature of CMS waivers, a review of past results will not be fully indicative of future operations, which are expected to change. The current

relaxed standards for supervision requirements may remain at some level, which would help increase the capacity of existing health care personnel and help mitigate provider shortages. Operationally, providers performing services at certain locations, such as skilled nursing facilities, may spend less time performing the same number of patient visits through effective use of telehealth.

The temporary allowance of certain codes previously excluded from the Medicare telehealth list will facilitate the collection of significant claims and outcomes data for subsequent analysis. If successful, there should be sufficient evidence to support adding these codes to the approved telehealth list permanently under a Category II process. Therefore, in the longer term, what we ask our providers to do and the technologies they use to do it may change.

As a result, the composition of resources to establish and provide services will likely change. Provider groups will need less physical space, support staff required to perform services may be reduced and hours of operation may change. Given these factors, a valuator may need to make many normalization adjustments to project operations and finances into the future. As the new standard of what provider entities will look like continues to develop, valutors should carefully document inputs and assumptions based on interviews with management and their knowledge about competitors' ability to provide telehealth services.

Conclusion

As telehealth increases, valutors should consider its potential impact on an entity being valued. COVID-19 has provided an opportunity for services to be performed in places not previously covered at levels of reimbursement that may not continue. A full retraction of current telehealth flexibilities is not expected, but the new normal remains undefined. For telehealth, valutors should document identified risks, including the risks of not performing telehealth services, and thoughtfully consider how telehealth may impact an entity's operations, resource needs, and costs structures in the future. **VE**



Richard Romero, CVA, ABV, CHFP, PAHM, is a senior vice president at Coker Group. For more than 20 years, he has provided services related to healthcare consulting, valuation of financial arrangements and businesses, hospital and physician integration, telehealth, regulatory compliance, and litigation support. He has served as an instructor for the NACVA/CTI, earning Instructor of Great Distinction in multiple years. More information at www.cokergroup.com. Email: rromero@cokergroup.com.