BETTER MEDICARE ALLIANCE

Telehealth in Medicare Advantage: Policy Issues and Recommendations

WHITE PAPER NOVEMBER 2019

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I. Overview of Telehealth

Telehealth refers to the use of telecommunication technologies and electronic information to support and expand access to delivery of health services. The definition of telehealth differs across federal and state agencies and continues to evolve. The Administration and Congress are increasingly recognizing the value of telehealth by removing barriers to telehealth options that have the potential of improving access to care and health outcomes, particularly for chronically ill beneficiaries. Telehealth can especially benefit patients and providers in managing chronic conditions, such as congestive heart failure, diabetes, and chronic obstructive pulmonary disease.[1]

Telehealth is generally divided into four modalities:

- **Live video** is synchronous, two-way interaction between a patient and provider that uses audiovisual telecommunications technology.
- **Store-and-forward** is the asynchronous transmission of recorded health information, typically videos or images, through a secure electronic communication system for evaluation by another provider. This modality is most widely used in dermatology, radiology, pathology and ophthalmology.[2]
- **Remote patient monitoring** is the collection and transmission of individual medical data from a patient in one location to a provider in a different location via electronic communications technologies.
- **Mobile health** is health care and information supported by mobile communication devices such as cell phones.[3]

Telehealth Can Improve Access to Care for Beneficiaries

Expanding telehealth benefits in federal programs, including Medicare Advantage, has the potential to improve access to care for beneficiaries with limited access to providers, particularly those who are homebound, lack transportation, are unable to drive, and/or live in rural counties. In addition to shifting treatment to lower-cost sites of care and reducing potential time and distance barriers, telehealth can also improve access to specialists, particularly in rural areas, where few may be available. Telehealth offerings and patient education about telehealth are currently limited, due to issues of lack of coverage for these services as well as lack of adoption of their use by providers and patients. Nonetheless, the telehealth benefits show promise for improving health outcomes and increasing care efficiency for a range of beneficiaries.

Recent polls have found that approximately half of people over age 65 are willing to try telehealth, and that number could increase as older adults become more accustomed to technology-driven services over time.[4,5] Studies also show that the 65-and-older age group may be even more likely than younger demographics to try telehealth for prescription renewals, chronic disease management, follow-up from inpatient procedures, and unexpected illness while traveling.[6]

Traditional fee-for-service (FFS) Medicare reimburses providers for a limited number of Part B services when delivered via a live telecommunications system instead of in-person.[7] Most telehealth services must be delivered via interactive live video telecommunications systems. Claims must be submitted based on an approved list of telehealth services that most beneficiaries can only receive at a designated rural originating site. Store-and-forward technology is only permitted under federal telehealth demonstration programs in Alaska and Hawaii.[8]

Medicare Advantage health plans, the managed care option in Medicare, must cover all telehealth services included in the basic Traditional FFS Medicare Part B benefits. Therefore, telehealth coverage in Medicare Advantage includes those in Traditional FFS Medicare, which limit eligible beneficiaries, originating sites, and services.[9] However, Medicare Advantage can utilize telehealth to improve beneficiary outcomes through benefit design and inclusion in supplemental benefits.[10] Table 1 highlights key telehealth coverage differences between Traditional FFS Medicare and Medicare Advantage.

TABLE 1

Telehealth Coverage in Traditional FFS Medicare vs. Medicare Advantage, 2018					
Payment System	**Total Program Spending**		**Coverage**	**Description of Payment**	**Provider/Plan Incentives**
	Billions	**Percent**			
FFS Medicare: Physician fee schedule	$70	12%	Limited to rural locations, certain services, two-way video, and originating site must be a facility	Separate payment for each service	Utilization can be increased without regard to costs or impact on outcomes
FFS Medicare: hospital, inpatient rehabilitation, long-term care hospital, end-stage renal disease, ambulatory surgical center, skilled nursing facility, home health, hospice	$269	46%	Flexibility to use telehealth services that best treat the patient	Payment contemplated as a part of a fixed payment for each patient encounter	Use telehealth if it reduces costs; at risk if cost of encounter exceeds fixed payment
Medicare Advantage	$170	29%	Must cover all FFS Medicare benefits and also have flexibility to offer services beyond FFS Medicare	The capitated payment includes telehealth services covered under FFS Medicare, but extra telehealth services must be financed with supplemental premiums or rebate dollars Note: As of 2020, Medicare Advantage plans will be able to include additional telehealth benefits in their basic benefit packages	Since the health plan is at risk if annual beneficiary costs exceed payment, the incentive is to use telehealth if it improves outcomes and/or reduces costs

Source; MedPAC, Report to the Congress: Medicare Payment Policy, 2018

The uptake of telehealth services in Medicare has grown rapidly in recent years but remains low. According to the Medicare Payment Advisory Commission (MedPAC), between 2014 and 2016, the number of Traditional FFS Medicare beneficiaries using telehealth services rose from 68,000 in 2014 to 108,000 in 2016, a 57 percent increase. Beneficiaries with hypertension, depression, and diabetes utilized telehealth services the most in 2016. In 2017, CMS reported 219 or 8 percent, of Medicare Advantage plans, covered remote patient monitoring services. In addition, 2,115 Medicare Advantage plans, or 77 percent, covered remote access technologies that included email, two-way video, and nurse call-in telephone lines.[11] As the baby boomers age into Medicare, experts predict the use of telehealth will increase and the market will grow to a $36.2 billion industry by 2020.[12]

This white paper provides an overview of telehealth coverage in Traditional FFS Medicare and Medicare Advantage. The paper also identifies recent policy changes that seek to expand access to telehealth services for Medicare beneficiaries. Finally, it recommends policies that remove barriers to telehealth access in Medicare Advantage.

II. Telehealth in Traditional FFS Medicare

While telehealth includes many different types of electronic and telecommunications technology to support remote clinical health care, Traditional FFS Medicare only pays for certain telehealth services under Part B. Generally, the patient and provider must speak face-to-face via a telecommunications system. Only in select demonstration programs can services be delivered through another means—namely, store-and-forward technology. However, research suggests that expanding telehealth could reduce Medicare costs. For example, in a controlled study of eleven nursing homes, researchers found reduced billable costs where facilities switched from on-call to telehealth physician coverage due to decreases in hospitalizations.[13]

Traditional FFS Medicare beneficiaries' use of telehealth services has increased rapidly in recent years. According to MedPAC, telehealth visits per beneficiary increased 79 percent in Traditional FFS Medicare between 2014 and 2016, accounting for 0.3 percent of Part B spending among FFS beneficiaries. In 2016, Medicare beneficiaries used 9.5 telehealth distant site services per 1,000 Traditional FFS Medicare Part B beneficiaries, compared to 7,800 total physician visits per 1,000 beneficiaries. Between 2014 and 2016, the number of Traditional FFS Medicare beneficiaries using telehealth services increased from 68,000 to 108,000, or 57 percent. In 2016, 99 percent of Medicare's telehealth services were synchronous meaning that these services occurred along with in-person visits; fewer than 1,000 encounters were provided asynchronously, meaning they were provided without accompanying similar in-person services.[14]

The Medicare beneficiaries who used telehealth tended to be under age 65, disabled, and dually eligible for Medicare and Medicaid. Many had chronic mental health conditions. Beneficiaries accessing telehealth averaged about three telehealth visits per person per year in calendar year 2014. Medicare spent an average of $182 per beneficiary on telehealth services, for a total of about $14 million. Most telehealth visits (62 percent) were provided to beneficiaries younger than 65 years old.[15] The most common services delivered were physician office services and mental health services.

Patient Location

A patient's location when receiving telehealth services is called the "originating site." Medicare restricts coverage for telehealth services to rural counties and geographic areas that are considered a Health Professional Shortage Area or areas outside of a Metropolitan Statistical Area.[16] Medicare may cover telehealth services if a person lives in a rural area and only if they are located at one of the following places when they receive telehealth services:

- Hospitals
- Critical Access Hospitals (CAH)
- Hospital-based or CAH-based Renal Dialysis Centers
- Skilled Nursing Facilities
- Community Mental Health Centers
- Physician or practitioner offices
- Rural Health Clinics
- Federally Qualified Health Centers[17]

Beginning July 1, 2019, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act removed originating site geographic restrictions and included a patient's home as an originating site for telehealth for substance use disorders or a co-occurring mental health disorder.

Eligible Providers

Under current law, Medicare limits the types of health care professionals who can provide covered telehealth services. The following health care providers are eligible to provide care via telehealth:

- Physicians
- Nurse practitioners
- Physician assistants
- Nurse midwives
- Clinical nurse specialists
- Certified registered nurse anesthetists
- Clinical psychologists and clinical social workers
- Registered dietitians or nutrition professionals[18]

Eligible Services

Beneficiaries can use telehealth for various types of consultations and follow-up appointments. When provided via telehealth, appointments usually last between 30 and 70 minutes and involve a problem-focused history and examination, as well as straightforward decision-making. Diabetes patients can receive self-management training services through telehealth. In addition, telehealth services for end-stage renal disease (ESRD) are included in the monthly capitated payments for patients who qualify for Medicare through that route. Telehealth can also be used for preventive services, such as smoking cessation, alcohol misuse, and neurobehavioral status exams. For mental health, telehealth services include annual depression screening, behavioral therapy, and family psychotherapy.[19]

Billing and Payment

Providers submit claims for telehealth services using Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes provided by CMS. Medicare Administrative Contractors pay physicians based on the fee schedule for covered telehealth services. Medicare pays for remote patient monitoring, remote interpretations of diagnostic tests, and services done via real-time, interactive communication technology rather than a face-to-face appointment. Section 1834 of the Social Security Act limits payment for telehealth to rural areas, but the Bipartisan Budget Act (BBA) of 2018 removed certain geographic limitations. Medicare can now pay for certain home dialysis services for ESRD patients, as well as telehealth services in certain Accountable Care Organizations (ACOs).

Physician Fee Schedule Proposals

The Secretary of the U.S. Department of Health and Human Services (HHS) outlines provider and facility payment in the Physician Fee Schedule (PFS) annually. Payment for telehealth services is dependent on the patient's location. Generally, in Traditional FFS Medicare, only beneficiaries in rural areas can receive coverage for telehealth services, and only certain types of providers can be paid for delivering telehealth services.[20] The HHS Secretary cannot change the geographic, patient setting, provider type restrictions because the limitations are in statute.[21, 22]

The 2018 PFS reflected the desire for more use of telehealth services. It included reimbursement for remote patient monitoring and CPT codes for telehealth for the first time. It also allowed reimbursement for a new service when a physician has a brief non-face-to-face check-in with a patient via communications technology to assess whether the patient should make an office visit with the following conditions:

- It cannot originate from a provider service offered in the previous seven days or lead to a service within the next 24 hours or soonest available appointment.
- Store-and-forward communication technology may only be reimbursed if it is used to determine whether an office visit or other service is warranted.
- Interprofessional consultations via communications technology may only be reimbursed (1) to prevent a specialist visit and (2) when a phone or internet-based interaction between the treating practitioner and the consulting practitioner would suffice.
- Care management and counseling treatment for substance use disorders may be covered through a new bundled payment.

The 2019 PFS aimed to further increase access to telehealth services further. CMS outlined various proposals to modernize Medicare physician payments for "communication technology-based" services that are not subject to the Section 1834 telehealth limitations:

- ***Reimbursement for Brief Communication Technology-based services*** (e.g., a virtual check-in): Rather than incorporating non-face-to-face communication between a patient and provider into the payment for the visit itself, the 2019 PFS outlined separate payments for a newly defined type of physician services using communication technology. These services involve when a provider has a brief non-face-to-face check-in to assess whether the patient needs to come in for a hospital visit.
- ***Remote Evaluation of Pre-Recorded Patient Information:*** CMS pays physicians separately when they use a patient-generated video or image to evaluate a patient's condition. Originally, payments for this service was only permitted in Alaska or Hawaii as part of a federal telehealth demonstration, but effective January 1, 2019, this service will not be subject to those geographic restrictions. If the remote evaluation results in an office visit, the remote service will be bundled into the office visit, rather than treated as a separate bill.
- ***Payments for consultations between providers:*** CMS finalized separate payments for interprofessional internet consultations that require a patient's verbal consent for each consultation.
- ***Elimination of requirements for substance use disorder treatment:*** As part of the **SUPPORT** for Patients and Communities Act, there are no longer originating site geographic requirements for telehealth services to treat substance-use disorders.[23]

Telehealth Quality and Cost Savings

Various studies have shown telehealth improves quality of care and reduces health care costs. One report from the Rural Broadband Association showed that telehealth can reduce hospital costs by more than $20,000 on average, per facility. These savings benefit both Traditional FFS Medicare and commercial health plans.

Additionally, telehealth improves efficiency by decreasing wait times for non-emergencies. One analysis found that telehealth appointments for non-emergency situations cost $55 less out-of-pocket than an in-person visit. In addition to savings for hospitals, telehealth has helped save patients money as well.[24] In a HealthMine survey of 500 insured individuals, 93 percent of those who used telehealth reported cost savings.[25]

A meta-analysis of telehealth studies that included 93 eligible trials (22,047 participants) sheds additional light on this topic. The wide range of conditions encapsulated in the trials included cardiovascular disease, diabetes, respiratory illnesses, and psychiatric conditions, and the appointments involved oversight, treatment, rehabilitation, and patient education through either remote monitoring or video conferencing. The meta-analysis revealed benefits to telehealth across conditions. For instance, using telehealth for heart disease led to similar health outcomes as face-to-face appointments, and virtual appointments for diabetes treatment improved patients' self-monitoring of blood glucose levels.[26]

Changes in the Bipartisan Budget Act of 2018

The Bipartisan Budget Act (BBA) expanded coverage options by removing several limitations around geography, patient setting, and type of provider delivering the services via telehealth.

- ***Home kidney dialysis:*** As of 2019, beneficiaries with ESRD receiving home dialysis may choose to receive clinical assessments via telehealth without originating site and geographic requirements.
- ***Stroke diagnosis and treatment:*** As of January 2019, geographic and facility requirements for stroke care via telehealth no longer apply. In addition, HHS may provide guidance on the diagnosis, evaluation, or treatment of symptoms of acute stroke.
- ***ACOs coverage:*** Starting in 2020, Accountable Care Organizations (ACOs) may provide allowable telehealth service in the home, waiving originating site and geographic requirements.[27] In addition, FFS beneficiaries will be able to prospectively and voluntarily select an ACO-participating professional who is available via telehealth as their primary care provider and for purposes of being assigned to that ACO, potentially expanding telehealth's reach further.[28]
- ***Medicare Advantage coverage:*** Medicare Advantage plans may include delivery of telehealth services in a plan's basic benefits.

The Congressional Budget Office has determined that coverage of telehealth in Medicare would neither increase nor decrease spending, making it budget neutral.[29]

III. Telehealth in Medicare Advantage

Medicare Advantage, also called Part C, is an option within Medicare that allows seniors and individuals with disabilities to receive their Medicare benefits through a private integrated managed care plan. Medicare Advantage may also include additional supplemental benefits—benefits that are not covered under Traditional FFS Medicare—such as vision, hearing, and dental coverage. Medicare Advantage plans must cover the same telehealth services that Traditional FFS Medicare covers, as well as services that are adjunct to covered benefits (e.g., a call with a clinician about a test result). Medicare Advantage plans can also provide extra telehealth services through supplemental benefits, which are funded using rebate dollars or additional premiums.[30] However, in practice, telehealth requirements in Medicare Advantage largely mirror those in Traditional FFS Medicare, so eligible beneficiaries, originating sites, and services are limited.[31]

Researchers have found that certain telehealth services in Medicare Advantage can expand access to care, improve care quality, and reduce costs. One study found telehealth services used in a Health Buddy Program by a small care management program for chronically ill Medicare Advantage patients reduced spending and led to better clinical outcomes.[32] Another study found telehealth can be a low-cost alternative to care administered in the emergency department.[33]

Telehealth in the Medicare Advantage Bid

Currently, Medicare Advantage plans must cover all services covered by Traditional FFS Medicare, and those services are subject to the same limitations as Traditional FFS Medicare. Therefore, the expansion of telehealth benefits in Traditional FFS Medicare translates into an expansion of telehealth services in Medicare Advantage. On April 5, 2019, CMS issued final rules implementing section 50323 of the BBA of 2018, which enables Medicare Advantage plans to provide telehealth benefits in bid amounts as a basic benefit, rather than as a supplemental benefit. Beneficiaries will no longer need to pay additional

premiums or copays to access telehealth services. As a basic benefit, telehealth only includes in-network providers; services from out-of-network providers would be paid as a supplemental benefit. Allowable telehealth benefits include services available under Part B and services that are identified each year as clinically appropriate. Beneficiaries must be able to decide whether to receive a service in-person or via telehealth. In addition, Medicare Advantage plans must identify that the telehealth benefit is clinically appropriate to provide electronically. Medicare Advantage plans also must comply with the same federal provider selection and credentialing requirements as in-person practitioners. CMS estimates that this rule will save $557 million over 10 years from reduced travel time.[34]

Value-Based Insurance Design

The value-based insurance design (VBID) model of 2020 will test four service delivery innovations. As part of the 2020 VBID models, Medicare Advantage plans can propose how telehealth services will augment their current provider networks. If a network includes three or more providers in the service area, Medicare Advantage plans can explore new ways telehealth could be used to expand care, such as designing a network that comprises one-third of the required in-network providers for a specialty. For rural areas with few providers, plans can propose how they will use telehealth to expand their networks, including in counties where the plan is not available. This could improve access to care, as well as increase the range of providers and specialists available to beneficiaries in those counties. CMS requires that patients will still be able to choose in-person facilities while testing how telehealth impacts care quality and costs.

CMS's 2019 Proposed Interoperability Rule

On February 22, 2019, CMS proposed a rule to allow patients and providers to access health information in interoperable forms allowing different entities to share, access, and use data seamlessly. The purpose of the rule is to ensure that an individual's health information is properly and fully transferred if he or she changes plans or providers. The rule is expected to be finalized by the end of 2019.

The rule would require payers to make health information available electronically through an application programming interface (API). Plans would need to implement APIs to make claims and encounter data available to enrollees. With the enrollee's permission, information transferred through the API would include adjudicated claims, encounters with capitated providers, cost-sharing, and clinical data. MA plans would be required to report encounter data on all benefits, including Part D, no later than one business day after the data are received. Encounter data should include dates of service, payment information, and enrollee cost-sharing. This rule includes a new requirement for Medicare Advantage to coordinate care by exchanging the US Core Data for Interoperability data set, if requested by an enrollee when they change plans. Information should be shared when initiated by the enrollee and incorporated into the plan's systems. By exchanging this data set, the proposed rule would encourage coordination of care and streamline prior authorization because providers would not need to personally intervene with the enrollee's health care plan.

CMS also is proposing a requirement for Medicare Advantage and other managed care plans to participate in trust networks to improve interoperability. A trusted exchange network allows for secure exchange of electronic health information and establishes rules for interoperability.

Telehealth in the Medicare Advantage Supplemental Benefits

MA plans must receive CMS's approval to provide telehealth as supplemental benefits beyond what is provided under Medicare Part B. Medicare Advantage plans can provide telemonitoring and web-based phone technologies, as well as medication therapy management for Medicare Advantage Prescription Drug (MA-PD) health plans. When it reviews supplemental benefits, CMS ensures that telehealth benefits are available for beneficiaries, but that they are not substitutes for in-person services included in the FFS benefit. CMS also ensures that plans meet network adequacy standards without relying on telehealth services. In 2017, CMS reported 219, or 8 percent of Medicare Advantage plans, covered remote patient monitoring services. In addition, 2,115, or 77 percent, covered remote access technologies, including email, two-way video, and nurse call-in telephone lines. Medicare Advantage plans have asked for greater flexibility to expand their supplemental benefit offerings to improve beneficiary access to adequate and convenient care.

Humana has continued to expand members' access to medical care through telehealth via the providers Doctor on Demand and MDLive. As of Jan. 1, 2018, telehealth is available to Humana Medicare Advantage members in 27 states and Puerto Rico. Individuals covered by Humana Group Medicare have access to telehealth at the start of 2018. Telehealth is also available through Humana health plans offered by employers.

IV. Policy Recommendations

1. CMS should allow Medicare Advantage health plans to go beyond telehealth benefits available under Part B, by broadening the categories of clinically appropriate telehealth services annually designated by the HHS Secretary.

2. To ensure adequate access to telehealth services and more easily engage beneficiaries, CMS and other stakeholders should provide user-friendly technology platforms that are seamless and convenient for all beneficiaries to use. This could include plan and provider applications that provide simple and streamlined interfaces that are compatible with a variety of mobile devices (e.g., cell phones, computers, and tablets). In addition, CMS should ensure telehealth services are available in multiple languages through both multilingual providers and qualified translators in Medicare Advantage.

3. CMS should seek ways to allow and encourage Medicare Advantage plans to test innovative telehealth care models and expand services that reduce costs or improve outcomes, while ensuring beneficiaries have appropriate protections to receive care in-person if preferred.

4. CMS should accommodate innovative care delivery models by allowing telehealth and mobile providers to count towards network adequacy, especially for rural areas.[35] Telehealth should be able to enable a Medicare Advantage health plan operating in a county in a rural Health Professional Shortage Area or outside of a Metropolitan Statistical Area to meet network adequacy standards, if the area would not otherwise have Medicare Advantage options.

5. CMS should include telehealth as an eligible encounter in Star Ratings measures. Changes need to be made to some Healthcare Effectiveness Data and Information Set measures that currently require a visit for the denominator, numerator, or exclusion. CMS should allow telehealth and/or remote access technology encounters to be counted as eligible encounters for the relevant portion of the measure—that is, counting as part of a measure, such telehealth and/or remote access technology visits are equivalent to or a reasonable replacement for in-person visits for relevant clinical areas.[36] Including telehealth in the quality measures underlying the Star Ratings calculations would provide a more accurate indication of plan quality.

6. Telehealth rules should allow for Medicare enrolled physicians licensed in another state to provide appropriate services. New rules are needed to lift the current requirement that clinicians be licensed in the state in which the patient being treated is located. Such a change would provide relief for telehealth programs operating across state lines from adhering to onerous state-level physician and nurse regulations.[37]

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