Cultivating innovation poses difficult challenges to policy makers in a society that relies on the creativity and competitive spirit of private actors to improve the day to day lives of their constituents. The policymakers want to harness the positive aspects of such a system while safeguarding against the risks posed by private actors engaging in conduct that inures to their benefit without real benefits to the public, or even causing identifiable harms. Some common regulatory regimes in the United States reflect this dynamic, and in health care two of the most notable are 1) the process by which the FDA regulates the development of new drugs and devices, and 2) the regulatory mechanisms used by states to review capital expenditures by hospitals and other health care providers. While the stakes might be different, policy changes with the goal of addressing deficiencies in the delivery of care pose the same core dilemma to policy makers of relying on the behavior of private actors in exchange for benefiting from their expertise.

This threat to observing desired outcomes from innovative changes to the delivery of care can be magnified or mitigated depending on the nature of the policy intervention. Policymakers can either place focused limitations on the conduct of interest or they can alter the background incentives that influence the behavior of private actors with respect to the conduct of interest and other actions within the same policy sphere. Some of these difficulties are intrinsic to the agency problems associated with relying on private actors to use the tools afforded by the policy change address the care delivery gaps that motivated policymakers to act. When the policy sphere under examination is encouraging innovation in the delivery of health care those options for steering private actors toward realizing desired outcomes translate into upstream macro level changes or downstream micro level changes. Examples of a macro level change from the status quo would be the movement to a single payer system, implementation of budgets for providers, or the expansion of the scope of health sector's obligations. By contrast, common micro level changes are prior authorization requirements, scope of practice limitations, or targeted financial incentives. Macro level policy changes can more comprehensively change the incentive structures that motivate healthcare sector participants and achieve behavior change outcomes more closely aligned with expectations; especially if they are done in a fashion that minimizes multi-payer complexities. Yet, political actors engaged in making the policy change can lack the necessary breadth of legal authority or the political ability to make changes on that scale. That means that micro level approaches will be predominant, and in the complex multi-payer system that exists in the U.S., manifold awkward or potentially countervailing steps in the direction of encouraging innovation will fill the void.

The use of telehealth to address access, cost, and quality of care issues in the delivery system is a good vehicle for illustrating how this dynamic operates in practice. Telehealth's value from a public policy perspective is premised on the potential that it holds for increasing access to care, increased practitioner support for patient lead care management (e.g., chronic conditions, drug regimen compliance, specific populations of interest/need), and ultimately decreased spending on avoidable care episodes. Because these
benefits rely entirely on providers using the telehealth under conditions that yield the desired benefits, policymakers have acted to cultivate those benefits of telehealth and hedge against the *25 risks using predominantly micro level approaches that hedge against those agency risks but also limit the scope of realizable benefits. 7

Telehealth's primary benefit is often framed in terms of resolving a market failure with respect to the availability of specific healthcare resources that are either actually or constructively absent. Rural settings are emblematic of both dimensions due the difficulties that patients face in traveling to access needed care, and the professional staffing or medical resource limitations that would otherwise limit the availability of desired services outside of a reasonable catchment area. 8 Conditions that give rise to lack of access are not only limited to circumstances tied to geography but also those services that have been chronically underfunded or otherwise marginalized in their availability. Behavioral health services, particularly mental health care, serves as a particularly poignant example. 9 Both types of scarcity could be resolved by other types of upstream policy interventions that would seek to correct these market failures, 10 but the appeal of telehealth is in part that it offers a relatively fewer financial and political challenges as a solution.

*26 There is also the value of telehealth as a maximizer of the role of individual patients in better managing their own health, under the direction of a medical professional. Typically, these telehealth interventions take the form of remote monitoring digital applications, or other non-interactive methodologies, but they can also include face-to-face communications. 11 The value of telehealth in this frame is the conjoined benefits of reduced costs and improved quality associated with a reduction in acute care episodes and improved quality of life for patients struggling to manage chronic conditions. In other words, the relative value tradeoff of avoided higher cost of care episodes is not only a victory for patient quality of life but also reduced public and private expense. 12

However, all the access, cost, and quality value propositions of telehealth innovation are tied to the appropriateness of its use and calls into focus the agency concerns that policymakers have about whether these benefits will be realized in practice. Even though macro level payment incentives changes would most effectively achieve those desired outcomes, 13 they can be more politically perilous. 14 This has led policymakers to pursue expansions of telehealth in narrow ways to achieve those benefits. But there is a tension between the narrowly tailored rules around the utilization of telehealth services designed to maximize the desired benefits, and the increased complexity that is created when each payer's approach is so uniquely tailored. 15 That accurately describes what has occurred at *27 the federal and state level where the most commonly observed policy approaches involve limitations on the use of telehealth on the basis of modality, practitioner, service line, and care episode circumstances. 16 While policy makers have also sought to balance out those limits with efforts to incentivize the adoption and use of telehealth services through *28 changes to payment policy, 17 those changes have been criticized as slow, 18 ineffective, 19 or potentially undermining the cost saving value telehealth. 20

There is however some indication that policy opportunities are starting to become available to change underlying provider incentives around the use of telehealth. 21 While these efforts are focused on reducing some of the agency concerns that exist under current payment structures, only some of them are doing so in a multi-payer fashion, leaving in place the multi-payer complexities that can continue to disincentivize provider embrace of innovative telehealth services. If these positive signs are not the beginning of a further shift in policy focus then future attempts to graft new innovations like telehealth onto the current ill-suited fee-for-service chassis will continue to be tentative, limited, and ad hoc; and the magnitude of the realized benefits will continue to reflect that.

Footnotes

a1 Mr. Canella is the Legislative Director and Counsel to State Senator James T. Welch. The views and opinions expressed in this article are those of the author and do not necessarily reflect the official policy or position of Senator Welch, or the Massachusetts Senate. Mr. Cannella received his J.D. from Boston University School of Law in 2014 and his
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4 See Taressa K. Fraze et al., Quality of Care Improves for Patients with Diabetes in Medicare Shared Savings Accountable Care Organizations: Organizational Characteristics Associated with Performance, 21 POPULATION HEALTH MANAGEMENT 401 (2018); EJ Emanuel et al., Using Behavioral Economics to Design Physician Incentives That Deliver High-Value Care, 164 ANNALS INTERNAL MED. 114 (2016) (noting the potential for value-based care to achieve desired provider behavior changes provided that new incentive structures be responsive to expected patterns of known behavior).


6 Erin Shigekawa, Margaret Fix, et al., The Current State Of Telehealth Evidence: A Rapid Review, 37 HEALTH AFFAIRS 12 (Dec. 2018), available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05132 (Feb. 27, 2019). The authors' study found that there is limited evidence to support the view that telehealth services that are capable of substituting for in persons services are in fact doing so or increases access to those services. Id.


result in high burnout and turnover rates within provider organizations”. Id. It has actually been shown that when behavioral health clinics are properly funded, they can provide competitive salaries which in turn could make their services more accessible. Id.

See Stephanie Anthony et al., Ready for Reform: Behavioral Health Care in Massachusetts, BLUE CROSS MA. FOUNDATION (2019), available at https://bluecrossmafoundation.org/sites/default/files/download/publication/Model_BH_Report_January%202019_Final.pdf (highlighting the importance of telemedicine amongst many methods to enhance access to behavioral health services). Some of the reasons why Massachusetts should implement telemedicine in providing behavioral health services include increasing the available behavioral health workforce, changes to behavioral health payment methodologies, and correcting gaps in coverage across payers. Id. Massachusetts recently have expanded its MassHealth program to allow for the use of telemedicine for regarding behavioral health services to improve access to care with the help of technological means. Id. See also Eric Wicklund, Massachusetts Embraces Telemental Health for Medicaid Members, MHEALTH Intelligence (Feb. 15, 2019), https://mhealthintelligence.com/news/massachusetts-embraces-telemental-health-for-medicaid-members; BLUE CROSS MA, TELEHEALTH (TELEMEDICINE) - BEHAVIORAL HEALTH (2018), https://provider.bluecrossma.com/ProviderHome/wcm/connect/51b9faff-46f6-41a0-b46c-143f8d117f30/Telemedicine-BH_payment_policy.pdf?MOD=AJPERS&CVID= (last visited Feb. 27, 2019). Additionally, Blue Cross Blue Shield has recently implemented reimbursement for behavioral health telehealth services. Id.

See Laurence C. Baker, Integrated Telehealth And Care Management Program For Medicare Beneficiaries With Chronic Disease Linked To Savings, 30 HEALTH AFF. 1689, 1689-1697 (2011), https://www.healthaffairs.org/doi/10.1377/hlthaff.2011.0216 (discussing health spending reductions for patients using telehealth programs). Specifically, there was a finding of 7.7-13.3 percent savings per person per quarter from a handheld device that prompts patients with daily questions about their knowledge and behavior that are tied to their specific diagnoses. Id.

Robert S. Rudin, et. al., Paying For Telemedicine, 20 THE AMERICAN JOURNAL OF MANAGED CARE 983 (2014). “Telemedicine has the potential to reduce healthcare costs, increase access to healthcare, and improve health outcomes. However, despite these prospective advantages, telemedicine has been adopted in only limited circumstances.” Id. at 983. See generally Who Pays for Telemedicine and Telehealth, eVisit (May 26, 2018), https://evisit.com/resources/who-pays-for-telemedicine-telehealth/ (discussing telemedicine and telehealth advantages and changes). But cf Jon Brooks, Telehealth Doctor Visits May Be Handy, But Aren't Cheaper Overall, npr.org (March 26, 2017), https://www.npr.org/sections/health-shots/2017/03/26/519543337/telehealth-doctor-visits-may-be-handy-but-arent-cheaper-overall (considering telehealth may not actually be a cheaper alternative to regular doctor visits).

See, e.g., Joe VerValin, The Rise and Fall of Vermont's Single Payer Plan, THE CORNELL POL. REV. (July 13, 2017) http://www.cornellpolicyreview.com/issue-53/vermonts-single-payer-plan/. In June of 2017, Vermont's attempt to institute a universal healthcare system failed as Governor Shumlin announced the initiative had become too costly. Id. Studies show however, that the initiative failed for political and institutional reasons, not purely economic reasons. Id. See generally Rudin supra note 13 at 983. Health plans are reluctant to cover telemedicine services as part of current payment arrangements. Id. See also Kathleen m. Vyborny, Legal and Political Issues Facing Telemedicine, 5 ANNALS OF HEALTH L. 61 (1996) (discussing the unique political and legal issues involved in the practice of telemedicine).


16 See Telehealth Services, MEDICARE LEARNING NETWORK (Feb. 2018), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Telehealth-Services-Text-Only.pdf. Medicare currently runs the gamut with restrictive requirements for telehealth service coverage across all three dimensions. Id. The Medicare beneficiary must be located in a qualifying rural area at a qualifying originating site (eight different options), the telehealth service must come from a distant site practitioner recognized by Medicare as eligible for payment for telehealth services, the interaction between the patient and the practitioner must be via real-time interactive audio or video communication, and the CPT code that applies to the encounter is recognized as a telehealth service. Id. Movement by CMS to expand even the list of acceptable CPT codes offers a further example of the challenges posed by using a fee-for-service structure to encourage telehealth. See Nathaniel M. Lacktman & Olivia King, Medicare Proposes (and Rejects) New Telehealth Services for 2019, HEALTH CARE LAW TODAY (Aug. 7, 2018), https://www.healthcarelawtoday.com/2018/08/07/medicare-proposes-and-rejects-new-telehealth-services-for-2019/. See also Johanna Butler & Jennifer Reck, Overcoming Payment Challenges to Realize the Promise of Telehealth, NASHP (July 31, 2018), https://nashp.org/overcoming-payment-challenges-to-realize-the-promise-of-telehealth/(Feb. 27, 2019) (noting that coverage disparities across payers creates a disincentive for providers to embrace telehealth).


18 Karen Rheuban, et al., Telemedicine: Innovation has Outpaced Policy, 16 JAMA OF ETHICS 1002, 1004-06 (2014) (describing how slow policy changes are a barrier for telemedicine adoption).

19 Carol K. Kane and Kurt Gillis, The Use Of Telemedicine By Physicians: Still The Exception Rather Than The Rule, 37 HEALTH AFFAIRS 1923 (2018) (observing that limited utilization may reflect that high upfront costs of adoption have not been outweighed by current regulatory changes). See also Jeongyoung Park, et al., Are State Telehealth Policies Associated With The Use Of Telehealth Services Among Underserved Populations?, 37 HEALTH AFFAIRS 2060 (2018) (finding that adoption and utilization of telehealth services is not reaching targeted populations of need despite efforts to increase access). But see, Marcia M. Ward, et al., Use Of Telemedicine For ED Physician Coverage In Critical Access Hospitals Increased After CMS Policy Clarification, 37 HEALTH AFFAIRS 2037 (2018) (finding that the CMS policy change had concurrent access improvement and cost reduction effects among participating emergency departments).

20 Katherine Restrepo, The Case Against Telemedicine Parity Laws, JOHN LOCKE FOUNDATION (Jan. 15, 2018), https://www.johnlocke.org/research/telemedicine/ (arguing that payment parity locks in the in-person rates for teleheath services and a reduction in licensure barriers would preserve the opportunity for cost savings while increasing the availability of telehealth eligible providers).
