MEDPAC Medicare Payment Advisory Commission

STATEMENT FOR THE RECORD

Temporary modifications of Medicare policies in response to the coronavirus public health emergency

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Statement of
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Committee on Finance
U.S. Senate

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The Medicare Payment Advisory Commission (MedPAC) is a small congressional support agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly. The Commission would like to thank Chair Wyden and Ranking Member Crapo for the opportunity to submit a statement for the record today.

The Congress and the administration granted temporary modifications to Medicare policies to enable providers, health plans, and others to effectively respond to the coronavirus pandemic. While many of these actions have been helpful in addressing the short-term issues presented by the pandemic, continuing those changes indefinitely would have drawbacks. Therefore, policymakers should be cautious about extending them beyond the duration of the public health emergency (PHE) or other scheduled expiration date.

Introduction

The Commission acknowledges the catastrophic consequences the coronavirus pandemic has had on all Americans and the health care delivery system. Medicare beneficiaries are at particular risk of developing COVID-19, and those over 65 years old are more likely to suffer complications and die compared to those who are younger and have fewer comorbidities. Non-White beneficiaries have faced disproportionately high rates of mortality due to COVID-19, reflecting, in part, longstanding inequities in the health care system. The Commission also recognizes the heroic work performed by the nation's health care workers, who have been on the front lines of this health crisis for more than a year, and thanks them for their tireless dedication and service.

The coronavirus pandemic has put our nation's health care system under enormous strain. Starting in March of last year, cases of patients infected with the coronavirus began to rise sharply at institutional settings, like hospitals and nursing homes. Hospital emergency rooms and intensive care units were regularly filled with patients affected by the pandemic, and beneficiaries in nursing homes have accounted for a disproportionate share of fatalities from COVID-19.

Meanwhile, the volume of ambulatory care services furnished to Medicare beneficiaries dropped sharply last spring as patients delayed or avoided care, and access to some services was curtailed to avoid spreading the disease. The number of ambulatory care services furnished to Medicare beneficiaries in the spring of 2020 was about half of the volume of the same services furnished during the same period the year before. The sudden decline in service volume during this period placed many providers under financial stress and may have put patient health and well-being at risk.

Actions taken to modify Medicare policies in response to the public health emergency

As the coronavirus emerged in the U.S. and our health care system confronted extraordinary challenges, the Secretary of Health and Human Services first declared the public health emergency in January 2020.[1] Starting in March 2020, CMS and the Congress made numerous changes to Medicare policies and granted regulatory flexibilities aimed at helping health care providers respond to the pandemic. We applaud CMS and policymakers for acting rapidly to provide a comprehensive array of policy modifications and flexibilities during an unprecedented time.

According to a report from the Commonwealth Fund, the administration and Congress modified more than 200 Medicare program policies and requirements between January and July 2020 (Podulka and Blum 2020). In addition, CMS has been issuing subregulatory flexibilities to providers and plans since the PHE began. Some of these measures have been phased out, but many of these temporary policy changes are scheduled to remain in effect for the duration of the PHE.

In general, the steps taken by CMS and the Congress are time limited and intended to support providers in diagnosing and treating COVID-19 patients by reducing or eliminating certain regulatory requirements and enabling providers to treat Medicare beneficiaries under social distancing protocols. The regulatory and legislative changes fall into nine broad categories (Podulka and Blum 2020):

- Alternative care sites
- Benefits and care management
- Conditions of participation
- Expanded testing
- Payment systems and quality programs
- Provider capacity and workforce
- Reporting and audit requirements
- Safety requirements
- Telehealth

A plurality of the regulatory changes eased some provider eligibility requirements. Regulatory waivers allowed providers to furnish services outside the state where they are enrolled and permitted beneficiaries to receive care in settings other than acute care hospitals (e.g., homes and skilled nursing facilities) to allow for surge capacity in those hospitals. Some of the changes suspended audits and quality reporting requirements or granted more flexibility over which

[1] Under section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. On January 31, 2020, the Secretary first determined the existence of a coronavirus PHE since January 27, 2020, based on confirmed cases of COVID-19 in the U.S. Since then, the coronavirus PHE has been renewed five times, most recently on April 15, 2021, and is scheduled to expire on July 20, 2021 (Office of the Assistant Secretary for Preparedness and Response 2021).

measures to report. CMS has also expanded access to telehealth services in a variety of ways, including temporarily eliminating geographic restrictions on where such services can be provided and expanding the types of services that can be furnished remotely.

Although the pandemic-related policy changes and flexibilities have touched almost every part of the Medicare program, I want to focus on two areas where the changes are especially important: telehealth and post-acute care.

Telehealth: The changes made to Medicare's telehealth coverage and payment policies enabled more types of services to be furnished remotely to more Medicare beneficiaries. These changes contributed to a substantial increase in the number of Medicare-covered services furnished via remote technologies, which helped to offset the decrease in in-person clinician visits.

Post-acute care: CMS modified numerous post-acute care (PAC) policies and requirements to preserve hospital capacity for beneficiaries with COVID-19. These actions enabled inpatient rehabilitation facilities and long-term care hospitals to treat certain hospital-level patients that do not meet certain requirements for these PAC settings and, in some cases, be paid the higher PAC-level payments. These waivers also extended skilled nursing facility coverage to beneficiaries who normally would not qualify.

The temporary waivers and other policy changes gave providers the flexibility to maintain access to care under social distancing guidelines and helped providers to respond to surges in COVID-19 cases by providing capacity beyond the acute care setting. These have been important tools for providers during the pandemic, but policymakers would be remiss in thinking that the extending these measures has only the potential for good. The underlying policies and regulations that have been waived or altered are designed to protect beneficiaries, support program integrity, and minimize potential overuse and misuse based on the incentives of the payment systems. As decisions are made about which pandemic-related measures should be continued, policymakers need to account for the fact that not all actors in the health care system are well-intentioned, and remain vigilant in protecting the Medicare program, beneficiaries, and taxpayers.

Telehealth

Medicare coverage of telehealth services before the PHE was limited by statute under the physician fee schedule (PFS). Before the PHE, Medicare covered telehealth services if they were provided to beneficiaries who received the service at a clinician's office or certain health care facilities (known as "originating sites") located in a rural area, with some exceptions.[2] Medicare

[2] Medicare pays for some telehealth services outside of rural areas and in any location, including a patient's home, including telehealth services for substance use disorders, for end-stage renal disease patients receiving home dialysis, and for mental health conditions (if the physician or practitioner has furnished an in-person service to the individual within the 6 months prior to the first time they furnish the telehealth service, and during subsequent periods that the Secretary would determine). Medicare also covers telehealth services to treat patients with a stroke in hospitals in urban and rural areas.

has historically been cautious about covering telehealth services because of uncertainties about the impact of telehealth on total spending, quality, and program integrity.

Prior to the PHE, the Commission evaluated the use of telehealth in the Medicare program and whether telehealth services covered under commercial plans should be incorporated into the Medicare fee-for-service (FFS) program (Medicare Payment Advisory Commission 2018). Our analysis of a sample of commercial insurers found a lack of uniformity in how these insurers covered telehealth services. Consequently, we did not make recommendations about covering specific telehealth services in Medicare. Instead, the Commission recommended that policymakers should use a set of principles (access, quality, and cost) to evaluate individual telehealth services before covering them in Medicare.

To increase access to care and help limit community spread of COVID-19 during the PHE, Medicare temporarily expanded coverage of telehealth under the PFS to all Medicare beneficiaries, including telehealth visits provided to patients at home (Table 1).

Table 1. Selected temporary telehealth expansions to the physician fee schedule during the public health emergency

	Pre-PHE	During the PHE
Who can receive telehealth services?	Clinicians can provide telehealth services to Medicare beneficiaries in certain originating sites in rural areas (e.g., a clinician's office or hospital but not the beneficiary's home).	Clinicians may provide telehealth services to Medicare beneficiaries outside of rural areas and in the patient's home.
Which types of telehealth services does Medicare pay for?	Limited set of services (does not include audio-only E&M visits).	CMS pays for over 140 additional services (e.g., emergency department visits, radiation treatment management). CMS allows audio-only interaction for some of the telehealth services and covers audio-only E&M codes.
How much does Medicare pay for telehealth services?	PFS rate for facility-based services (less than the nonfacility rate).	PFS rate is the same as if the service were furnished in person (facility or nonfacility rate, depending on the clinician's location). Same for audio-only visits.
What are the costs to beneficiaries?	Standard cost sharing.	Clinicians are permitted to reduce or waive cost sharing.

Note: PHE (public health emergency), E&M (evaluation and management), PFS (physician fee schedule). Under the PFS, clinicians who provide services in facilities such as hospitals receive a lower payment rate (the facility rate) than clinicians who provide services in offices (the nonfacility rate).

During the PHE, demand for telehealth services soared as providers and beneficiaries sought to reduce the risk and spread of infection by avoiding in-person visits. According to an analysis of FFS Medicare claims data from the first 6 months of 2020 and the first 6 months of 2019, there were 8.4 million telehealth services paid under the PFS in April 2020, compared with 102,000 in February 2020 (Medicare Payment Advisory Commission 2021). The number of telehealth

services declined to 5.6 million in June 2020, as the number of in-person services began to rebound. During the first 6 months of 2020, 10.3 million beneficiaries in FFS Medicare (32 percent of the total) received at least one telehealth service, compared with 134,000 beneficiaries during the first 6 months of 2019. The share of all primary care services conducted by telehealth rose dramatically from less than 1 percent in January 2020 to 47 percent in April.[3] The share declined to 31 percent in May and 18 percent in June as in-person primary care services rebounded. The Commission will analyze more recent claims data over the next year.

Rationale for telehealth expansion and potential safeguards

During the past year, the Commission discussed whether the temporary telehealth expansions should continue in Medicare after the PHE. Many providers and beneficiaries have described the benefits of increased access and convenience from telehealth during the PHE. Advocates of telehealth services support making the temporary expansion of telehealth in Medicare permanent after the PHE. They assert that these services can expand access to care, increase convenience to patients, improve quality, and reduce costs relative to in-person care. However, there is a risk that under FFS Medicare, telehealth services could supplement—rather than substitute for—in-person services, thereby increasing spending for Medicare and patients (Ashwood et al. 2017, Mehrotra et al. 2020). Telehealth could lead to higher volume if telehealth providers induce demand for their services, if the greater convenience of telehealth leads beneficiaries to use telehealth services more frequently than in-person services, or if additional in-person follow-up visits are required. Although there are some clinical trials comparing telehealth and in-person care, there is not yet evidence on how the combination of telehealth and in-person care affects quality of care and outcomes.

Expanding telehealth services also raises program integrity concerns. Telehealth companies have been involved in several large fraud cases, resulting in billions of dollars in losses for Medicare. For example, the Department of Justice (DOJ) recently charged defendants—including telemedicine companies—with submitting false and fraudulent claims worth more than $4.5 billion to federal health programs and private insurers (Department of Justice 2020). Telehealth technology makes it easier to carry out fraud on a large scale because clinicians employed by fraudulent telehealth companies can interact with many beneficiaries from different parts of the country in a short amount of time. In addition, if beneficiaries become more comfortable receiving care by telehealth, they might become more vulnerable to being exploited by companies that pretend to be legitimate telehealth providers.

In considering a permanent expansion of telehealth, it is important to balance the potential of telehealth to improve beneficiaries' access to care with the risk of higher spending due to overuse, while ensuring that beneficiaries receive high-quality care. In our March 2021 report to the Congress, we present a policy option for expanding FFS Medicare's coverage of telehealth services after the PHE (Medicare Payment Advisory Commission 2021). In developing this

[3] Primary care services include the following PFS services: office/outpatient evaluation and management (E&M) visits, home E&M visits, E&M visits to patients in certain non–inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care), audio-only E&M visits, chronic care management, transitional care management, Welcome to Medicare visits, annual wellness visits, e-visits, and advance care planning services.

policy option, we maintain our previous recommendation that policymakers should use the principles of access, cost, and quality to evaluate individual telehealth services before covering them under Medicare.

Under this policy option, policymakers should continue some telehealth expansions for a limited duration following the end of the PHE (e.g., one to two years) to gather more evidence about the impact of the telehealth expansions on total spending, access, patient experience, and outcomes of care. Policymakers should use this evidence to inform any permanent changes. First, Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location. Second, Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit. Third, to improve access to those without the capability to engage in a video visit from their home, Medicare should temporarily cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.

Other telehealth policies that were adopted during the PHE should end when the PHE ends. First, Medicare should return to paying the fee schedule's facility rate for telehealth services instead of paying either the facility or nonfacility rate, as it does during the PHE. CMS should also collect data from practices and other entities on the costs they incur to provide telehealth services and make any future changes to telehealth payment rates based on those costs. We expect the rates for telehealth services to be lower than rates for in-person services because services delivered via telehealth likely do not require the same practice costs as services provided in a physical office. Although telehealth may require upfront investments in technology and training, in the long run the marginal cost of a telehealth service should be lower than that of an in-person service (Mehrotra et al. 2020).

In addition, Medicare should require the same share of beneficiary cost sharing for telehealth as it does for in-person service after the PHE. Because telehealth services are more convenient for beneficiaries to access, they have a higher risk of overuse than in-person services, particularly in the context of a fee-for-service payment system in which providers have a financial incentive to bill for more services. Requiring beneficiaries to pay a portion of the cost of telehealth services would help reduce the possibility of overuse.

After the PHE, CMS should implement other safeguards to protect the Medicare program and its beneficiaries from unnecessary spending and potential fraud related to telehealth, including:

- applying additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians;
- requiring clinicians to provide an in-person, face-to-face visit before they order high-cost durable medical equipment or high-cost clinical laboratory tests; and
- prohibiting "incident to" billing for telehealth services provided by any clinician who can bill Medicare directly.

In future work, we will continue to monitor beneficiaries' and providers' experiences with telehealth in Medicare and the use of telehealth during the PHE. We plan to continue exploring

trends in telehealth use and spending using more recent Medicare claims data. This summer, we will ask clinicians and Medicare beneficiaries about their use of telehealth during focus groups, and we will ask beneficiaries and privately insured individuals about their use of telehealth during our annual telephone survey. In addition, we continue to meet with telehealth companies and other stakeholders and will regularly inform the Congress of our work.

Post-acute care

Institutional post-acute care (PAC) settings—skilled nursing facilities (SNFs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs)—provide care to patients who need skilled institutional care to recuperate and regain function, typically following an acute care hospital stay. The Medicare program maintains separate conditions/requirements of participation and coverage rules and uses setting-specific prospective payment systems (PPSs) to pay for stays in each setting. Distinct facility and patient requirements help ensure that care provided in each setting is consistent with Medicare coverage rules and help control unnecessary spending for care in high-cost settings when patients' conditions do not warrant this level of care.

During the PHE, CMS used its emergency and other waiver authority to modify numerous policies and requirements intended to preserve hospital capacity for beneficiaries with COVID-19 (Centers for Medicare & Medicaid Services 2021b). Waivers allowed IRFs and LTCHs to be paid the higher-level payments for some cases that do not qualify as IRF or LTCH stays, and they extended SNF coverage to beneficiaries who normally would not qualify for SNF stays. The SNF, IRF, and LTCH facility and patient requirements and PHE-related waivers are summarized below.

Skilled nursing facility requirement. Beneficiaries who need daily, short-term skilled nursing or rehabilitation care on an inpatient basis following a hospital stay of at least three days are eligible to receive covered services in SNFs. By limiting coverage to post-hospital "skilled" services, the program extends coverage for services similar to those provided to hospital inpatients, but at a lower level of care, and effectively excludes long-term care, which is not a covered Medicare benefit.

Skilled nursing facility waiver. During the PHE, CMS is waiving the requirement for a three-day prior hospitalization for coverage of a SNF stay for beneficiaries who experience dislocations or were otherwise affected by COVID-19. In addition, for certain beneficiaries who recently exhausted their SNF benefits, CMS authorizes renewed SNF coverage without first having to start a new benefit period. These waivers allowed facilities to "skill in place" beneficiaries who required skilled care without having to transfer them to a hospital for a three-day hospital stay and helped retain hospital capacity for COVID-19 patients. CMS estimated that about 16 percent of SNF admissions in fiscal year 2020 used a waiver, and the majority of those were attributed to the waived prior hospital stay requirement (Centers for Medicare & Medicaid Services 2021b).

Inpatient rehabilitation facility requirements. After an illness, injury, or surgery, some beneficiaries need intensive inpatient rehabilitation services, such as physical, occupational, or speech therapy. For a facility to receive payment as an IRF, 60 percent of its admissions must be for one of 13 conditions that typically require intensive rehabilitation therapy (referred to as the "60-percent rule"). To qualify for admission to an IRF, a beneficiary must be able to tolerate and

benefit from intensive therapy, typically defined as three hours of therapy a day at least five days a week (referred to as the "three-hour rule"). These Medicare requirements help ensure that only the most appropriate patients are eligible to receive care at this relatively costly setting, given that many beneficiaries are able to receive care at lower-cost settings.

Inpatient rehabilitation facility waiver. CMS is allowing IRFs to exclude from the calculation of their compliance with the 60-percent rule those patients who were admitted in response to the PHE. CMS is also waiving the three-hour therapy rule, as required by Section 3711(a) of the Coronavirus Aid, Relief, and Economic Security (CARES) Act. These waivers effectively allow IRFs to admit patients who would not normally qualify for IRF care and provide additional hospital beds for surge capacity in communities that need it. These cases may be paid the IRF PPS rates in freestanding IRFs in areas experiencing a surge during the PHE.[4]

Long-term care hospital requirements. Some patients with profound debilitation of multiple systems, frequently with ongoing respiratory failure, receive care in an LTCH. To be paid at the higher standard Medicare LTCH payment rate, a case must immediately follow an acute care hospital stay, not be a psychiatric or rehabilitation case, and the preceding hospital stay must include three or more days in an intensive care unit or the LTCH case must include mechanical ventilation services for at least 96 hours. If these requirements are not met, cases are paid at a lower "site-neutral" rate. In addition, to qualify for Medicare payment as an LTCH, a facility must have an average length of stay greater than 25 days for Medicare cases paid the LTCH PPS standard payment rate. Finally, if less than 50 percent of Medicare discharges qualify for the standard LTCH PPS rate, the facility is to be paid under the acute care hospital PPS until that share reaches 50 percent or higher. As with Medicare's IRF requirements, LTCH criteria were implemented to ensure that Medicare does not pay the high LTCH rates for lower-acuity cases that can be cared for in other, lower-resource intensive settings.

Long-term care hospital waiver. Consistent with section 3711(b) of the CARES Act, all cases admitted are being paid the LTCH payment rate, even those that normally would not qualify for the higher LTCH rate, for the duration of the PHE. In addition, all cases will be counted as discharges paid the LTCH PPS rate for purposes of calculating an LTCH's share of Medicare discharges that qualify for the standard LTCH PPS rate. In addition, CMS waived the 25-day average length-of-stay requirement to participate in the LTCH PPS when an LTCH admits or discharges patients to meet the demands of the PHE. These waivers enable LTCHs to treat a broad mix of patients, including overflow short-term acute care hospital patients, and be paid LTCH payment rates.

[4] A state (or region, as applicable) that is experiencing a surge means a state (or region, as applicable) that satisfies all of the following, as determined by applicable state and local officials: (1) all vulnerable individuals continue to shelter in place, (2) individuals continue social distancing, (3) individuals avoid socializing in groups of more than 10, (4) non-essential travel is minimized, (5) visits to senior living facilities and hospitals are prohibited, and (6) schools and organized youth activities remain closed (Centers for Medicare & Medicaid Services 2021a).

Waived PAC criteria should be reinstated when the public health emergency ends

The waivers of facility and patient requirements for SNFs, IRFs, and LTCHs are examples of policy changes that provide flexibility to expand capacity and reduce patient transfers for the duration of the PHE. The waivers allowed providers to be paid for Medicare patients that would not ordinarily qualify for payment in those settings or to be paid higher rates for those patients during the PHE, but there are compelling reasons to reinstate these waived requirements after the PHE is over. Making these changes permanent would roll back gains in defining appropriate use of costly settings and expose the Medicare program to increased spending. For example, until 2016, the lack of meaningful criteria for LTCH use resulted in admissions of less-complex patients who could be cared for appropriately in lower-cost settings. The Commission and CMS had long been concerned that caring for lower-acuity patients in LTCHs increased spending without demonstrable improvements in quality or outcomes (Medicare Payment Advisory Commission 2020). When "site-neutral" payments for less-complex patients were implemented starting in 2016 and LTCHs received lower acute hospital rates for these cases, providers responded by reducing the number of site-neutral cases treated in LTCHs (Medicare Payment Advisory Commission 2021).

Studies of the impact of eliminating the SNF prior-hospitalization requirement (along with other changes) under the Medicare Catastrophic Coverage Act suggest that spending would increase substantially without the three-day rule to act as a guardrail for program spending (Aaronson et al. 1994, Laliberte et al. 1997, Office of Inspector General 1991). To balance the objectives of updating the policy to reflect current hospital practices yet protect the Hospital Insurance Trust Fund, in 2015 the Commission recommended that the three-day policy be revised to allow up to two days spent in outpatient observation status to count toward the three-day prior hospitalization requirement (Medicare Payment Advisory Commission 2015). When the three-day hospital stay waiver is lifted, the Congress should revise it to allow two of the days in observation status to count towards meeting the required three-day stay.

While Medicare permitted the SNF three-day stay requirement to be waived for entities participating in bundled payment demonstrations, some entities did not take advantage of this flexibility (Dummit et al. 2018, Lewin Group 2019, The Lewin Group 2020). Similarly, not all Next Generation ACOs elected to waive the three-day stay requirement (NORC at the University of Chicago 2020). However, since these bundled payment entities and ACOs are at full risk, this experience may not be relevant to entities operating under traditional FFS Medicare. This is because they already have a financial incentive to control the total cost of care to Medicare, unlike providers not at financial risk under traditional Medicare.

In 2016, the Commission recommended design features of a unified payment system for post-acute care that would pay for PAC services based on patient characteristics and needs, rather than setting (Medicare Payment Advisory Commission 2016). Later, it outlined a patient-centered approach to align regulatory requirements so that providers would face similar regulatory requirements for treating similar patients (Medicare Payment Advisory Commission 2019). Until a uniform payment system is implemented and regulatory requirements are aligned, institutional PAC settings' patient and facility criteria provide important program safeguards against paying for unnecessary care and help ensure that care provided in costly, intensive settings is targeted to patients who can benefit from that level of care.

Policymakers should be cautious about making current flexibilities and policy modifications permanent

It is important to keep in mind the reasons that policies and rules in place prior to the pandemic exist. Many of the Medicare policy changes made in response to PHE affect important beneficiary protections, as well as measures designed to deter fraud, overuse, or inappropriate spending. The intended effects of the regulatory flexibilities and other changes to Medicare's policies are to maintain beneficiary access to needed services and help the health care system to respond to the pandemic, but these flexibilities can also have negative effects. For example, waiving conditions of participation can expand access and minimize provider burden, but looser regulations may also negatively affect quality of care and quality of life for patients and put Medicare at higher risk for waste and fraud by creating opportunities for those who wish to exploit the program to do so.

If it is determined that any temporary policy changes are leading to poor health outcomes, patient harm, or increases in fraud and abuse, policymakers should take immediate action to curtail those flexibilities prior to the end of the PHE. Likewise, some of the temporary policy changes that were viewed as necessary during the worst days of the PHE—such as increased payment rates for certain services—may no longer be needed as the effects of the pandemic wind down.

In other cases, decisions about whether to extend or make permanent policy modifications after they are scheduled to expire should be made based on evaluation of data collected not only during the pandemic, but also during more typical circumstances. That being said, we do not yet have reliable information about how policy modifications and flexibilities granted during the PHE have affected health status, access, spending, program integrity, and other important considerations. Furthermore, findings on the effects of policy changes based on data collected during a pandemic may not be generalizable to the post-pandemic environment. For instance, the impact of the modifications that increased use of telehealth on quality and cost of care are largely unknown and will take time to fully analyze, and findings from 2020 could be shaped by factors that may not be applicable after the pandemic.

Conclusion

MedPAC recognizes the tremendous challenges the coronavirus pandemic has imposed on beneficiaries, providers, and the rest of the health care system. We applaud the quick and decisive actions taken by the Congress and CMS aimed at maintaining access to care and enabling an effective response to the public health emergency. In general, the Commission has been supportive of the temporary waivers, flexibilities, and other changes to Medicare policies implemented during the PHE. We are supportive of continuing some of the telehealth expansions for a limited time, beyond the PHE, provided that adequate oversight and protections are in place to protect the Medicare program and beneficiaries. We would not advise extending the PAC waivers beyond the PHE.

The Commission is also supportive of efforts by this Committee and others to review the changes and make determinations about which, if any, flexibilities and policy changes should be continued, and which should be reinstated once the PHE ends. We realize many stakeholders see the benefits of less regulatory oversight and expanded coverage of services like telehealth, along

with other pandemic-related policy changes, and wish to see them made permanent. But the Commission is concerned about the implications of indefinitely continuing Medicare policy modifications and flexibilities that were granted in direct response to the unique circumstances of the coronavirus pandemic. There are trade-offs to extending PHE-related modifications, and the benefits of continuing these changes must be weighed against the potential drawbacks, including substantial spending and program integrity implications.

Although we are concerned about the potential for some of the waivers and coverage expansions to lead to overuse of services and reductions in quality of care, these modifications may not have the same drawbacks when implemented in alternative payment arrangements to traditional FFS where an entity is at financial risk for the cost and quality of care. In fact, many existing Medicare alternative payment models (APMs) contain waivers and flexibilities similar to those granted during the PHE. As noted earlier, many APMs permit beneficiaries to receive care in a SNF without a preceding three-day inpatient hospital stay, and there are fewer restrictions on telehealth compared to traditional FFS. The Commission is hopeful that the continued development of such models can help facilitate more flexibility for providers and expanded coverage of technologies such as telehealth, while minimizing the negative behaviors.

In closing, MedPAC urges the administration and the Congress to carefully consider how making waivers permanent will affect the quality of care beneficiaries receive, the willingness of providers to continue to participate in the Medicare program, and the already challenging issues of fiscal solvency and Medicare program integrity. The Commission plans to continue to follow the status of the temporary policy changes and waivers granted during the PHE and will be closely monitoring their impact on the program. Ultimately, all decisions about whether to continue these measures beyond the PHE should balance the benefits of expanding access to care and reducing administrative burden with the need to minimize the potentially negative effects that the rules and policies were originally designed to prevent.

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