Advising the Congress on Medicare issues

Mandated report: Telehealth services and the Medicare program

Zach Gaumer and Amy Phillips

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Presentation outline

- Overview of the mandate
- Project plan
- Definition of telehealth services and framing the issue
- Mandate question 1:
  - Current Medicare coverage of telehealth services
  - Use of telehealth under the physician fee schedule (PFS)
- Discussion and next steps

MedPAC report mandated by Congress in the 21st Century Cures Act of 2016

By March 15, 2018, MedPAC shall provide information to the committees of jurisdiction that identifies:

1. The telehealth services for which payment can be made, under the fee-for-service program under Medicare Parts A and B; (September)

2. The telehealth services for which payment can be made under private health insurance plans; (October)

3. Ways in which telehealth services covered under private insurance plans might be incorporated into the Medicare fee-for-service program (including any recommendations for ways to accomplish this incorporation). (November)

Telehealth definition: Services fall into six general categories

Telehealth services include various combinations of:

- Services (e.g., primary care, mental health, neurology),
- Technologies (e.g., two-way video, email, phone, text), and
- Modalities (e.g., internet, internal IT system, monitoring center)

Basic medical care and consultations	Remote monitoring	Asynchronous transmission of data
1. Patient in the presence of a clinician connecting to a second clinician 2. Patient at home connecting to a clinician 3. Clinician connecting to another clinician (patient not present)	4. Patient in the hospital or other facility 5. Patient at home, referred to as remote patient monitoring (RPM)	6. The storing and subsequent forwarding of data such as images, scans, video, or written descriptions to a clinician for evaluation

MEDPAC

Background and framing the issue

- Interest in telehealth has grown in recent years
- Advocates: Telehealth expands access, increases convenience, improves quality, and reduces costs
- Critics: Telehealth services may increase costs because they supplement rather than substitute for in-person visits
- June 2016 MedPAC chapter:
  - Efficacy of telehealth services is mixed
  - Incentives for use differ among various payment systems
- Most Medicaid programs, DOD, and VA cover telehealth to varying degrees
- 34 states have passed telehealth parity laws that require commercial insurers to cover telehealth visits equal to in-person visits

Medicare covers telehealth in four areas of the program to varying degrees

1. Physician fee schedule (PFS) (constrained)
2. Other fee-for-service (FFS) payment systems (flexible)
3. Medicare Advantage (flexible)
4. CMMI initiatives (flexible)

Physician fee schedule (PFS): Telehealth coverage

- Coverage parameters:
  - Originating sites: Rural facilities and physician offices
  - Distant sites: Clinicians in any location
  - Modalities: Two-way video, and some store-and-forward
  - Services covered: Among others - office visits, kidney disease, mental health, substance abuse, nutrition, and pharmacy management
  - Constraints: Some limits on frequency of use
- Payment: Each discrete service paid separately

  (originating site = $25, distant site = 100% of PFS facility rate)
- Cost sharing: 20% (originating and distant site payments)
- Incentive: increase volume of services

Physician fee schedule (PFS): Telehealth coverage

- Telehealth services are contemplated within various PFS management codes:
  - Transitional care management (TCM)
  - Chronic care management (CCM)
  - Others:
    - 90-day global surgery
    - Behavioral health integration
    - Continuous positive airway pressure (CPAP) codes
- Remote interpretation of tests
- Cardiac monitoring
- Retinal imaging

Other Medicare FFS payment systems: Telehealth coverage

- Other FFS systems with telehealth coverage include:
  - Inpatient hospital, outpatient hospital, skilled-nursing facilities, long-term care hospitals, inpatient rehabilitation, dialysis facilities, home health, and hospice
- Payment: Telehealth contemplated in fixed payment for patient encounters
- Incentive: Use telehealth if it reduces costs (at risk if cost of encounter exceeds fixed payment)
- Reporting of telehealth costs to CMS
  - Included in cost report: hospitals, SNFs, LTCHs, IRFs, and dialysis facilities
  - Not included in cost report: home health and hospice

Medicare Advantage: Telehealth coverage

- Coverage parameters: Must mirror telehealth coverage under FFS
  - Flexibility to cover additional telehealth through supplemental premiums and rebate dollars
- Payment: Annual capitated payments
- Incentive: Use telehealth if it reduces costs (at risk if annual beneficiary costs exceed payment)

CMMI's two-sided ACOs: Telehealth coverage

- Coverage parameters: Waivers to cover telehealth in urban areas and in the patient's home
- Payment: Paid FFS rates, but bonus payments or losses tied to cost savings and quality
- Incentive: Use telehealth if it reduces costs (risk of not receiving bonus payment if annual beneficiary costs exceed target)

Telehealth use under the Medicare PFS

- Use was low in 2016
  - 108,000 unique beneficiaries (0.3 percent of Part B beneficiaries)
  - 9.5 telehealth visits per 1,000 Part B beneficiaries (7,800 total physician visits per 1,000 Part B beneficiaries)
  - $27 million for 319,000 encounters
- Use concentrated among few providers and beneficiaries
  - 10 percent of providers accounted for 72 percent of visits
  - 10 percent of beneficiaries accounted for 46 percent of visits
- Most common services:
  - E&M office visits (58 percent)
  - Mental health visits (23 percent)
  - Inpatient hospital or nursing care follow-up visits (13 percent)
  - Other: 2,000 ESRD visits and 2,000 telestroke visits

Telehealth use under the Medicare PFS….continued

- Rapid growth between 2014 and 2016:
  - 79 percent increase in visits per 1,000 beneficiaries (5.3 to 9.5)
  - 65 percent increase in spending ($16 million to $27 million)
- Most rapidly growing services:
  - Subsequent nursing care (263 percent)
  - Psychotherapy (180 percent)
  - Pharmacological management (148 percent)
- Growth most rapid in states with large rural populations
  - Mississippi
  - Alaska
  - Virginia

Characteristics of beneficiaries using telehealth services under the PFS in 2016

Characteristic	Telehealth users	All beneficiaries
Dually eligible (Medicare & Medicaid)	62 percent	20 percent
Rural	57 percent	20 percent
Mental health chronic conditions	56 percent	16 percent
Diabetes	23 percent	18 percent
Chronic obstructive pulmonary disorder	13 percent	7 percent
Average number of physician claims per beneficiary	49 claims	29 claims

Source: CMS Carrier and Denominator files

Summary

- Medicare coverage
  - Broadly available under some FFS systems, MA, and ACOs
    - Providers/payers bear some financial risk
    - Telehealth contemplated as part of a fixed payment
    - Incentive to use telehealth if it is efficient
  - Less flexibility under the PFS (rural and certain services)
    - Telehealth paid on FFS basis with volume
    - May increase costs if it is a supplemental service
    - Some blocks of PFS cover telehealth as part of a fixed payment
- Patterns of telehealth use under the PFS
  - Low use: primary and mental health visits, concentrated
  - Rapid growth: nursing care, psychotherapy, drug management
  - Telehealth users: Duals, rural, and mental health conditions

Discussion and next steps

- Questions about Medicare coverage and utilization?
- October: Coverage of telehealth services by commercial plans
- November: Discussion of incorporating elements of commercial plan telehealth coverage into the Medicare FFS program?