

CHAPTER

# 14

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**Telehealth in Medicare  
after the coronavirus  
public health emergency**

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# Telehealth in Medicare after the coronavirus public health emergency

## Chapter summary

During the coronavirus public health emergency (PHE), the Congress and CMS have temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and reduce their risk of exposure to COVID-19. Hospitals, physicians, and other providers have responded by rapidly adopting telehealth to provide continued access to medical care for their patients. Without legislative action, many of the changes will expire at the end of the PHE.

Although the temporary telehealth expansions affect virtually all settings of care, most of the changes affect the services paid under the physician fee schedule (PFS). Prior to the PHE, Medicare paid for a limited number of telehealth services only if they were provided to beneficiaries in a clinician's office or a facility in a rural area. Most telehealth services were paid at the lower PFS rate used to pay clinicians providing care in facilities, such as hospital outpatient departments (the facility-based rate), rather than the higher rate used to pay office-based clinicians (the nonfacility rate), because the practice expenses associated with furnishing telehealth services were presumed to be lower. During the PHE:

- Clinicians may bill for specified telehealth services provided to Medicare beneficiaries in any location, including their homes, and in urban as well as rural areas.

## In this chapter

- Use of telehealth during the public health emergency
- Telehealth expansions in FFS Medicare after the public health emergency
- Additional safeguards needed to protect Medicare and beneficiaries against telehealth-related unnecessary spending and fraud

- CMS has added over 140 PFS services to the list of services it will pay for when delivered through telehealth (e.g., emergency department visits, observation and inpatient care, nursing facility care, and home visits). Clinicians can bill for some of these services if they are provided using audio-only interaction, and CMS added new codes for audio-only evaluation and management visits.
- CMS pays the same rate it would pay if the service were provided in person (the PFS's facility-based or non-facility-based rate, depending on the clinician's location).
- Clinicians may reduce or waive beneficiaries' cost-sharing obligations for telehealth services.

CMS made these changes quickly out of necessity, and we applaud the agency for acting rapidly to preserve access to care during the PHE. We expect these telehealth expansions will remain in place throughout the PHE. There is ongoing debate about whether the expansions should be made permanent. The Commission has previously recommended that policymakers use the principles of access, quality, and cost to evaluate individual telehealth services before covering them under Medicare. There are some clinical trials comparing telehealth and in-person care, but at this time, there is not yet evidence on how the combination of telehealth and in-person care affects quality and costs in the Medicare program.

In this chapter, we present a policy option for expanding fee-for-service Medicare's coverage of telehealth services after the PHE. Under this policy option, policymakers should temporarily continue the following telehealth expansions for a limited duration (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on access, quality, and cost, and they should use this evidence to inform any permanent changes. During this limited period:

- Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location.
- Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit.
- Medicare should temporarily cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.

After the PHE ends, Medicare should return to paying the fee schedule's facility rate for telehealth services and collect data on the cost of providing these services.

In addition, providers should not be allowed to reduce or waive cost sharing for telehealth services after the PHE. CMS should also 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.

This chapter also describes CMS’s existing authority to offer telehealth flexibilities to clinicians participating in advanced alternative payment models, such as accountable care organizations. ■



## Background

Telehealth includes health care services delivered through a range of online, video, telephone, and other communication methods. Although many providers across multiple settings may deliver services via telehealth, Medicare does not always pay separately for such services. This chapter focuses on telehealth services that Medicare pays for separately under the physician fee schedule (PFS). Under the PFS, Medicare is limited by statute to paying only for telehealth services provided to beneficiaries who receive the service at a clinician’s office or certain health care facilities (known as “originating sites”) located in a rural area, with some exceptions (e.g., recent legislation covered mental health services provided by telehealth in urban and rural areas and in patients’ homes).<sup>1</sup> To increase access to care and help limit community spread of COVID-19 during the public health emergency (PHE), Medicare temporarily has expanded coverage of telehealth to all Medicare beneficiaries, including telehealth visits provided to patients at home.<sup>2</sup> Table 14-1 describes some of Medicare’s telehealth policies in the PFS before the PHE

and during the PHE (see text box, pp. 473–474 for more information about Medicare’s coverage and payment for telehealth services prior to the PHE).

During the PHE, many providers and patients have embraced telehealth, and there are calls to permanently implement the expansions. CMS made these changes quickly out of necessity, and we applaud the agency for acting rapidly to preserve access to care during the PHE. We expect the telehealth expansions will continue throughout the PHE. This chapter presents a policy option for policymakers and the Congress to consider in expanding telehealth in Medicare after the PHE.

## Use of telehealth during the public health emergency

The coronavirus pandemic had tragic effects on beneficiaries’ health in 2020 and changed the demand for and delivery of health care. In the physician sector, demand for telehealth services soared as providers and beneficiaries sought to reduce the spread of infection by avoiding in-person visits. According to our analysis of

**TABLE  
14-1**

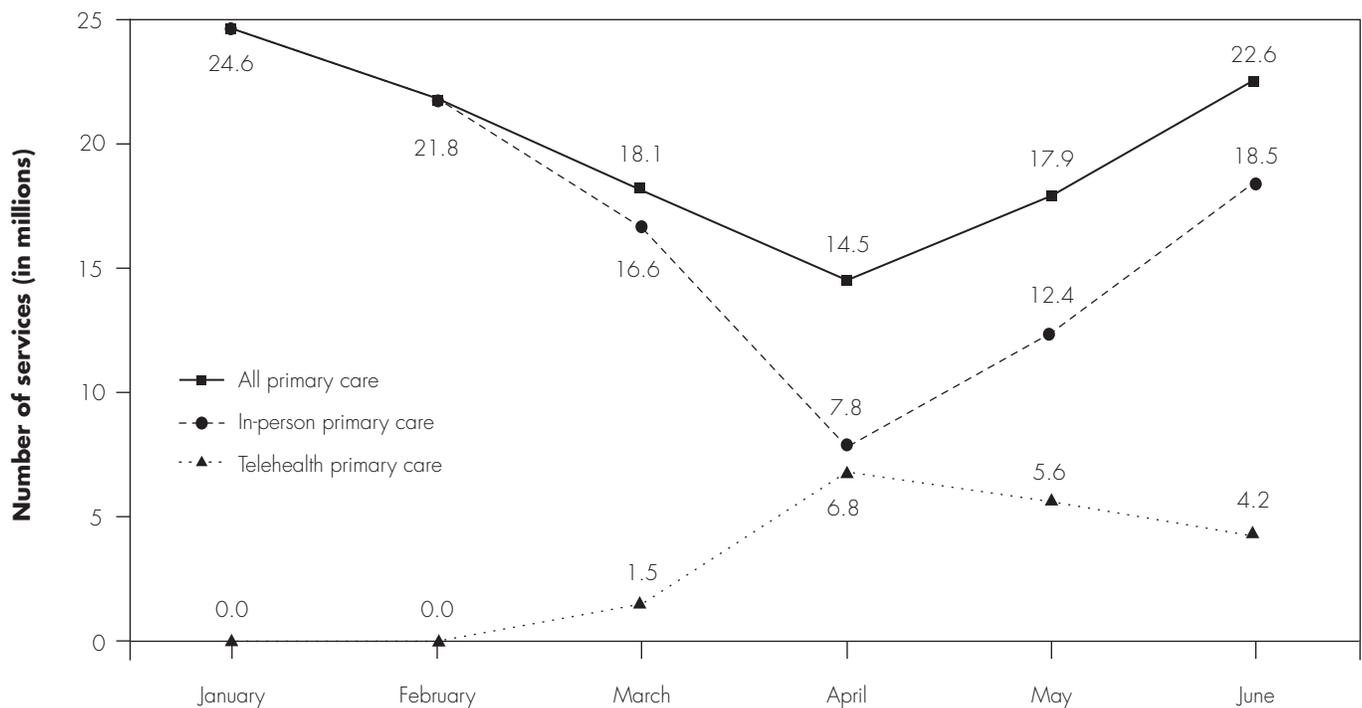
**Selected temporary telehealth expansions to the physician fee schedule during the public health emergency**

	Pre-PHE	During the PHE
<b>Who can receive telehealth services?</b>	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.
<b>Which types of telehealth services does Medicare pay for?</b>	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.
<b>How much does Medicare pay for telehealth services?</b>	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.
<b>What are the costs to beneficiaries?</b>	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).

**FIGURE 14-1**

**Primary care services provided via telehealth partially offset the drop in the number of in-person services, January–June 2020**



Note: Primary care services include the following physician fee schedule 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.

Source: Analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries.

fee-for-service (FFS) Medicare claims data, there were 8.4 million telehealth services paid under the PFS in April 2020, compared with 102,000 in February 2020. The number of telehealth services declined to 5.6 million in June 2020 (the latest month for which we have complete claims data), as the number of in-person services began to rebound. More than three-quarters (78 percent) of the telehealth services provided to FFS beneficiaries during the first six months of 2020 were primary care services, and 31 percent of the primary care services were audio-only evaluation and management (E&M) visits.<sup>3</sup> 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 growth of telehealth services partially offset the drop in the use of in-person services in March and April.

Between January and April 2020, the number of in-person primary care services provided to FFS beneficiaries dropped steeply from 24.6 million to 7.8 million (Figure 14-1). The share of all primary care services delivered by telehealth rose dramatically from less than 1 percent in January to 47 percent in April. The share declined to 31 percent in May and 18 percent in June as in-person primary care services rebounded.

### Telehealth expansions in FFS Medicare after the public health emergency

The Congress and CMS are under pressure to make the telehealth expansions permanent after the PHE, and both are considering such policy changes (Association of American Medical Colleges 2020, Ross 2020). Many

providers and beneficiaries have described the benefits of increased access and convenience from telehealth during the PHE. Advocates of telehealth services assert that these services can expand access to care, increase convenience to patients, improve quality, and reduce costs relative to in-person care. Others caution, however, that under FFS Medicare, telehealth services could supplement—rather than substitute for—in-person services, thereby increasing spending for payers and patients (Ashwood et al. 2017, Mehrotra et al. 2020). Telehealth could lead to higher volume if telehealth providers induce demand for their services or if the greater convenience of telehealth leads beneficiaries to use telehealth services more frequently than in-person services. Expanding telehealth services also raises program integrity concerns. Telehealth companies have been involved in several large fraud cases, resulting in several 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 might make it easier to carry out fraud on a large scale because clinicians employed by fraudulent telehealth companies can interact with many beneficiaries from many parts of the country in a short amount of time. In addition, if telehealth is expanded and beneficiaries become more comfortable receiving care through telehealth, they might become more vulnerable to being exploited by companies that pretend to be legitimate telehealth providers. For these reasons, Medicare has historically been cautious about covering telehealth services. In considering a permanent expansion of telehealth, a key issue is how to achieve the benefits of telehealth while limiting the risks to beneficiaries and the program.

Clinicians who participate in advanced alternative payment models (A-APMs), such as accountable care organizations, have greater flexibility to bill for telehealth services than other clinicians in FFS Medicare (see text box on A-APMs, pp. 464–465). These flexibilities preceded the PHE and will continue after it ends. Therefore, the Commission’s work focuses on expansions of telehealth services in FFS Medicare outside of A-APMs.

We discuss a policy option for expanding Medicare’s coverage of telehealth services after the PHE. In developing the policy option, the Commission maintains its previous recommendation that policymakers should

use the principles of access, quality, and cost to evaluate individual telehealth services before covering them under Medicare (Medicare Payment Advisory Commission 2018b). There are some clinical trials comparing telehealth and in-person care, but at this time, there is not yet evidence on how the combination of telehealth and in-person care affects quality and costs in the Medicare program. Therefore, policymakers should temporarily continue some elements of the telehealth expansions for a limited duration (e.g., one to two years) after the PHE to gather more evidence about the impact of the expansions on access, quality, and cost, and use this evidence to inform any permanent policy. Other elements of the policy option, such as how much to pay for telehealth services, address how Medicare’s telehealth policies should change immediately after the PHE ends.

### **Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location**

Prior to the PHE, Medicare paid for telehealth services provided to beneficiaries who received them at certain locations (known as “originating sites”) in rural areas. During the PHE, Medicare has temporarily expanded payment for telehealth services provided to all Medicare beneficiaries, including to patients at home. During focus groups we held in the summer of 2020, clinicians and beneficiaries supported continued access to telehealth visits with some combination of in-person visits. They cited benefits of telehealth, including improved access to care for those with physical impairments, increased convenience from not traveling to an office, and increased access to specialists outside of a local area. In our annual beneficiary survey, over 90 percent of respondents who had a telehealth visit reported being “somewhat” or “very satisfied” with their video or audio visit, and nearly two-thirds reported being “very satisfied.” Although telehealth can improve convenience and access, it is unclear how expanded availability of telehealth affects clinical outcomes and program spending outside of the PHE. Consequently, the Commission maintains that the Congress should temporarily give CMS the authority to pay for telehealth services provided to all FFS beneficiaries (regardless of geographic location), including to beneficiaries at home. After a period of time, policymakers should use data collected during this period in considering whether any permanent policy changes should be implemented, weighing the principles of access, quality, and cost.

## CMS has granted additional telehealth flexibilities to clinicians in advanced alternative payment models

CMS has provided clinicians in certain advanced alternative payment models (A-APMs) that have prospective beneficiary assignment with additional flexibility to bill Medicare for Part B services, including telehealth services. For example, the Center for Medicare & Medicaid Innovation (CMMI) created a waiver for Next Generation accountable care organizations (ACOs) that allows clinicians in an ACO to bill for telehealth services provided to their aligned beneficiaries in urban or rural areas and to beneficiaries at home.<sup>4</sup> They can bill for any service on CMS's approved list of telehealth services that is provided to beneficiaries in an originating site other than their home (e.g., a hospital or clinician's office) in an urban or rural area. They can bill for a smaller set of telehealth services provided to beneficiaries in their home, such as evaluation and management visits. Between 2016 and 2018, four Next Generation ACOs (8 percent of the total) used this waiver to provide telehealth services (NORC at the University of Chicago 2020).<sup>5</sup> In addition to the telehealth waiver, CMMI also allows

Next Generation ACOs to waive cost sharing for Part B services, which may include telehealth services.

CMS allows Medicare Shared Savings Program (MSSP) ACOs that bear two-sided risk and have prospective beneficiary assignment to bill for telehealth services provided to their aligned beneficiaries in urban or rural areas and to beneficiaries at home.<sup>6</sup> Clinicians in these ACOs are allowed to bill for any service on CMS's approved list of telehealth services. However, they can only bill for telehealth services provided to beneficiaries at home if such services are appropriate to furnish in a home (e.g., not inpatient visits).

There are potential benefits to allowing telehealth flexibilities for clinicians in A-APMs. First, the Commission has long supported the evolution of Medicare from fee-for-service to value-based payment such as A-APMs (Medicare Payment Advisory Commission 2020). Waiving telehealth restrictions for clinicians in A-APMs could be another incentive

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Temporarily allowing clinicians to bill for telehealth services provided to beneficiaries in any location also raises questions about the role of telehealth vendors in Medicare (see text box, pp. 466–467).

### **Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit**

Prior to the PHE, CMS allowed clinicians to bill for about 100 services provided by telehealth to beneficiaries in rural areas. CMS has established a regulatory process and criteria to review whether a service should be added or deleted from the list of allowable telehealth services. The criteria include whether the service is similar to an existing telehealth service in authorizing legislation or whether it demonstrates clinical benefit (see text box on

CMS's process for revising the list of allowable telehealth services, p. 468). Citing clinical benefit during the PHE, CMS has temporarily added over 140 PFS services to the list of telehealth services that Medicare will pay for, such as emergency department visits, radiation treatment management, and home visits. CMS has recently added nine of these services to the allowable telehealth services list, which means they will be permanently covered after the PHE. CMS has also allowed about 60 of these telehealth services to be billable through the calendar year in which the PHE ends to gather more evidence of potential clinical benefit (Centers for Medicare & Medicaid Services 2020c).

Some of the services added temporarily to the list of allowable telehealth services could improve access and quality or reduce program spending after the PHE.

## CMS has granted additional telehealth flexibilities to clinicians in advanced alternative payment models (cont.)

for clinicians to participate in these models. Second, because A-APMs require providers to assume at least some financial risk for Medicare spending or utilization and to be held accountable for quality of care, they have an incentive to improve quality while restraining the growth of spending or utilization. This incentive mitigates the concern that a broad expansion of telehealth could lead to additional Medicare spending. If telehealth leads to additional spending by an A-APM, this higher spending would be at least partially offset by penalties or lower bonuses.

However, there are some drawbacks to granting additional flexibilities to clinicians in A-APMs. First, doing so could be administratively complex for clinicians. We assume that telehealth and cost-sharing flexibilities would apply only to beneficiaries who are prospectively assigned (i.e., assigned at the beginning of a performance period) to an A-APM entity because clinicians would need to know at the time of the service whether a beneficiary is eligible for a telehealth or cost-sharing waiver. Some A-APM models use retrospective assignment, in which beneficiaries are

assigned to an entity at the end of a performance year. For example, MSSP ACOs have the option to choose retrospective assignment, in which beneficiaries are provisionally assigned to an ACO at the beginning of the performance year but final assignment is made at the end of the year. Consequently, a clinician in an ACO that uses retrospective assignment will not know definitively at the time of service whether a beneficiary is eligible for a waiver because the beneficiary's final assignment will not be determined until the end of the year. If this clinician provides a telehealth service under a waiver to a beneficiary who is not assigned to the clinician's ACO at the end of the year, the telehealth service could be denied. Therefore, to take advantage of a telehealth or cost-sharing waiver, clinicians in an A-APM would need to keep track of which of their Medicare patients are in their A-APM, which could be complicated because clinicians in an A-APM often see patients who are not assigned to their A-APM. Second, beneficiaries are often not familiar with ACOs and may be confused if they are treated differently by ACO clinicians than by other clinicians. ■

Therefore, CMS should continue to temporarily cover select services that the agency determines have the potential for clinical benefit. We favor this approach instead of permanently covering all of the telehealth services that are temporarily covered during the PHE. After a period of time, policymakers should use information gathered during the temporary period of coverage to consider permanently covering the additional telehealth services based on the principles of access, quality, and cost.

### **Medicare should temporarily cover certain telehealth services when provided by audio-only interaction if there is potential for clinical benefit**

Telehealth services payable by Medicare must be furnished using an interactive telecommunications system that includes two-way audio and video communication technology (Centers for Medicare & Medicaid Services

2020c). During the coronavirus PHE, however, CMS has waived this requirement because not all beneficiaries have the capability to engage in a video telehealth visit from their home. Specifically, during the PHE, CMS allows audio-only interactions to meet the requirements for some telehealth services based on the agency's clinical assessment (Centers for Medicare & Medicaid Services 2020b). For example, CMS pays for most behavioral health services that are provided through audio-only interaction, but not for audio-only physical therapy or eye exams. Telehealth services that are payable when provided by audio-only interaction are paid the same rates as those provided by audiovisual telehealth.

Allowing audio-only interaction for certain telehealth services can improve beneficiary choice and equity in access to care for beneficiaries who do not have access to the technology for a video telehealth visit. Also, during the Commission's clinician and beneficiary focus

## Vendors that provide direct-to-consumer telehealth services

Several vendors currently provide a range of telehealth services and technologies, from direct-to-consumer (DTC) telehealth visits for urgent care to the technology needed to enable telehealth communication. Telehealth companies also often have relationships with commercial, Medicaid, and Medicare Advantage health plans as well as employers to supply both the clinicians and technology to offer telehealth visits. As telehealth and digital health continue to evolve, the range of services offered by these companies will also continue to grow. This text box presents some preliminary research into telehealth vendors and their role in traditional Medicare.

Health systems currently work with telehealth vendors in several ways. Some systems outsource telehealth services to a company that supplies both the clinicians and the technology to perform telehealth visits. Health systems can also work in partnership with vendors, where the health system's clinicians perform telehealth visits using a vendor's technology. These two approaches can also be combined, with a health system's clinicians staffing telehealth visits during normal business hours

and a telehealth company supplying both the technology and the staff for after-hours visits. Some systems also contract with vendors to provide telehealth visits to patients who are seeking care in a state where the system's providers are not licensed.

Prior to the public health emergency (PHE), DTC telehealth vendors did not typically bill traditional fee-for-service (FFS) Medicare because their services were generally provided in a patient's home. With the expansion of telehealth services to all beneficiaries in their homes during the PHE, clinicians who provide services through these companies now have the option to bill Medicare. One vendor (Doctor on Demand) stated that it enrolled some of its employed primary care clinicians in FFS Medicare, set up a process to check patient eligibility, and is working on the connectivity to transmit Medicare claims (Jennings 2020). Doctor on Demand is currently waiving cost sharing for Medicare Part B beneficiaries (Doctor on Demand 2020). Another company (MDLive) has announced it is preparing to offer telehealth services to Medicare Part B beneficiaries (Jennings 2020).

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groups conducted in the summer of 2020, we learned that sometimes a scheduled telehealth visit would switch to audio-only because of technical issues at the start of the visit. Since Medicare has not previously covered audio-only interactions, there is limited evidence on the quality and cost effects. Under the Commission's policy option, CMS should continue to temporarily cover some telehealth services delivered through an audio-only interaction when the agency determines there is potential for clinical benefit. These services should include audio-only E&M visits with established patients. After a period of time, policymakers should consider permanently allowing audio-only interaction for some telehealth services while weighing the principles of access, quality, and cost.

### **After the PHE ends, Medicare should return to paying the fee schedule's facility rate for telehealth services and collect data on the cost of providing these services**

Prior to the PHE, most telehealth services generated two Medicare payments: (1) a payment to the originating site where the beneficiary was located (e.g., a clinician's office or hospital) and (2) a payment to the clinician at the distant site who provided the telehealth service. In 2021, Medicare pays the originating site a flat fee of \$27 per service. However, CMS does not pay an originating site fee if the beneficiary is not located at an originating site (e.g., if the beneficiary is at home). Medicare pays the clinician at the distant site a PFS payment based on the type of service provided (e.g., an E&M office/

## Vendors that provide direct-to-consumer telehealth services (cont.)

Temporarily allowing clinicians to bill for telehealth services provided to beneficiaries in their home raises questions about the role of these DTC telehealth vendors in Medicare. These companies can expand access to urgent care if a beneficiary's primary care provider is not accessible when the patient needs such care. They might also provide behavioral health services, which could improve beneficiaries' access to these services. However, if beneficiaries receive DTC services from clinicians who are not their usual source of care, their care may become fragmented.

The Commission's policy option would allow providers—including clinicians who provide services through a DTC telehealth vendor—to temporarily bill Medicare for telehealth services provided to beneficiaries in their home, which raises questions about how much Medicare should pay for services provided through a DTC vendor. One argument is that services provided by clinicians through a DTC telehealth vendor should be paid less than telehealth services provided by clinicians who also see patients in person because DTC vendors probably have lower costs. Clinicians providing services through a DTC

telehealth vendor do not need to acquire office space or equipment (e.g., exam tables, blood pressure cuffs) because they do not see patients in person. While it is logical to expect that these lower practice costs should translate to lower Medicare payments for telehealth services provided by DTC vendors, in practice, such a policy would be difficult to implement. Medicare claims do not contain information on clinicians' employers or corporate affiliations. Nor does Medicare Part B currently make payment distinctions on the basis of ownership, raising the possibility that Medicare would need to define DTC vendors as a new provider type. Nevertheless, during the period of temporary expansion after the PHE, CMS should collect cost information from providers to determine whether services provided through a DTC telehealth vendor should be paid at lower rates than telehealth services provided by clinicians who also treat patients in person, and if so, what those rates should be. Before paying lower rates for telehealth services provided by DTC vendors, CMS would need to explore whether it is feasible to distinguish between different types of telehealth providers. ■

outpatient visit). Many PFS services have two payment rates, depending on whether they are provided in a facility setting (e.g., a hospital or a skilled nursing facility) or a nonfacility setting (e.g., a freestanding clinician's office) (see text box on PFS payment rates, p. 470). Prior to the PHE, CMS paid clinicians at the distant site the PFS's lower, facility-based payment rate instead of the higher, nonfacility rate because the practice expenses for telehealth services are presumed to be lower than for services provided in person in a clinician's office. (The portion of the payment for the clinician's work does not vary by location.) During the PHE, however, CMS pays the same PFS rate for a telehealth service that it would pay if the service were furnished in person (either the facility

or nonfacility rate). For example, if the service would have been provided in a clinician's office, CMS pays the distant-site clinician the PFS nonfacility rate.<sup>7</sup>

When the PHE ends, CMS should return to paying the PFS facility rate for telehealth services provided by distant-site clinicians. CMS should then collect data from practices and other entities on the costs they incur to provide telehealth services and make any 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

## CMS's criteria and process for revising the list of allowable telehealth services

In 2002, CMS established a process for adding services to or deleting services from the Medicare allowable telehealth services list (Centers for Medicare & Medicaid Services 2020b, Centers for Medicare & Medicaid Services 2020c). This process provides the public with an ongoing opportunity to submit requests for adding services, which are then reviewed by CMS. Any changes to the Medicare allowable telehealth services list are made through the annual physician fee schedule rule-making process.

Under CMS's review process, potential telehealth services are reviewed based on one of three categories of criteria.

**Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list.** In reviewing these requests, CMS looks for similarities between the requested and existing telehealth services that are included in the authorizing legislation. Among these similarities are 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. The agency also looks for similarities in the telecommunications system used to deliver the service, such as the use of interactive audio and video equipment.

**Category 2: Services that are not similar to those on the current Medicare telehealth services list.** CMS reviews whether the billing code's description of the service applies when the service is furnished via telehealth. They also review whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include a description of relevant clinical studies that demonstrate the service

furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings. CMS's evidentiary standard of clinical benefit does not include minor or incidental benefits. CMS cites some examples of clinical benefit:

- 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

CMS does not consider the potential spending implications of adding a service to the telehealth list.

**Category 3: Services that were added during the public health emergency.** In response to the coronavirus pandemic, CMS created a third category of services that are added to the Medicare-allowable telehealth services list on a temporary basis through the end of 2021 (Centers for Medicare & Medicaid Services 2020e). This new category includes services that were added during the public health emergency and which likely have a clinical benefit when furnished through telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. ■

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). Therefore, continuing to set rates

for telehealth services equal to rates for in-office services after the PHE ends could distort prices and lead clinicians to favor telehealth services over comparable in-person services, even when an in-person service may be more clinically appropriate.

## **After the PHE ends, providers should no longer be permitted to reduce or waive cost sharing for telehealth services**

Prior to the PHE, beneficiaries were subject to the same cost-sharing liabilities for telehealth services as they were for other services. However, the Office of Inspector General (OIG) has issued a policy statement notifying clinicians that they will not be subject to administrative sanctions for reducing or waiving cost sharing for telehealth services during the PHE (Office of Inspector General 2020).<sup>8</sup>

A few clinicians in our focus groups said they were waiving cost sharing for telehealth visits and several were unsure. Some said that waiving cost sharing would not have much of an effect since so many of their Medicare patients have supplemental coverage. About 80 percent of FFS beneficiaries have supplemental coverage through employer-sponsored insurance (30 percent of beneficiaries), Medigap plans (29 percent), or Medicaid (22 percent), which typically covers some or all of Part B's cost-sharing requirements (Cubanski et al. 2018). Consequently, most FFS beneficiaries are shielded from most cost-sharing responsibilities for telehealth services, even if their clinicians do not waive cost sharing during the PHE.

Nevertheless, some FFS beneficiaries do not have supplemental coverage for Part B cost sharing, and these beneficiaries could be influenced by a cost-sharing waiver. 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 an FFS 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. Therefore, after the PHE has ended, we encourage OIG to discontinue its policy that allows clinicians to reduce or waive cost sharing.

Requiring clinicians to collect cost sharing from beneficiaries for telehealth services should not impose an additional burden on them. In the case of beneficiaries with Medigap coverage, CMS sends information from Part B claims to most Medigap plans, which pay the cost-sharing amount directly to the clinician (Centers for Medicare & Medicaid Services 2020a). For beneficiaries who have other supplemental coverage, clinicians are able to collect the cost-sharing amount from the beneficiary's supplemental payer rather than bill the beneficiary directly. Although the cost sharing for telehealth services may be relatively small, clinicians currently collect cost

sharing for other services with low payment rates, such as electrocardiograms.<sup>9</sup>

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## **Additional safeguards needed to protect Medicare and beneficiaries against telehealth-related unnecessary spending and fraud**

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We assume that CMS would monitor telehealth services to prevent fraud, waste, and abuse after the PHE, using its regular program integrity tools. However, CMS should permanently establish three additional safeguards after the PHE to protect the program and beneficiaries from unnecessary spending and potential fraud related to telehealth:

- apply additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians or who bill for a high number of services in a week or a month,
- require clinicians to provide an in-person, face-to-face visit with a beneficiary before they order expensive durable medical equipment (DME) or expensive clinical laboratory tests, and
- prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly.

### **Apply additional scrutiny to outlier clinicians**

After the coronavirus PHE, CMS should apply additional scrutiny to clinicians who are outliers in terms of volume of telehealth services compared with other clinicians. To do so, CMS could examine the distribution of clinicians by the number of telehealth services they bill per beneficiary and identify clinicians in the extreme tail of the distribution. In this way, CMS could compare clinicians in the same specialty because some specialties might provide a large share of their services through telehealth. Alternatively, CMS could use billing information to estimate the amount of time that a clinician spends on telehealth services during a week or month.<sup>10</sup> If this estimate exceeds the total number of hours in a week or month, CMS could consider this clinician an outlier.

Next, CMS could instruct the Medicare administrative contractors (MACs), which process Medicare claims, to apply additional scrutiny to telehealth claims submitted

## Physician fee schedule payment rates are usually lower when a service is provided in a facility setting compared with a nonfacility setting

Medicare’s physician fee schedule (PFS) usually pays different rates depending on whether a service is provided in a facility setting (e.g., a hospital) or a nonfacility setting (e.g., a freestanding clinician’s office). The portions of the PFS payment rate for the clinician’s work and professional liability insurance (PLI) are the same in both settings, but the portion for practice expense is usually lower when a service is delivered in a facility setting because Medicare makes a separate payment to the facility to cover the cost of the physical space, medical supplies, medical equipment, and clinical staff time.<sup>11</sup>

For example, the 2021 PFS rate for a Level 3 office/outpatient evaluation and management visit (Current Procedural Terminology code 99213) includes the following components: the clinician’s work (\$45.36), PLI (\$3.49), and practice expense (\$19.19 in a facility and \$43.62 in a nonfacility setting) (Table 14-2). The total PFS facility rate for this service is \$68.04 and the total PFS nonfacility rate is \$92.47. When this service is provided in a hospital outpatient department, Medicare pays the PFS facility rate and makes a separate payment to the hospital under the hospital outpatient prospective payment system (\$118.74 in 2021). ■

**TABLE  
14-2**

**Physician fee schedule payment rate for a Level 3 office/outpatient E&M visit is lower in a facility setting than a nonfacility setting, 2021**

	Facility	Nonfacility
Work component	\$45.36	\$45.36
PLI component	3.49	3.49
Practice expense component	<u>19.19</u>	<u>43.62</u>
Total payment rate	68.04	92.47

Note: E&M (evaluation and management), PLI (professional liability insurance). The Current Procedural Terminology code for this service is 99213. Facility settings include hospitals. Nonfacility settings include freestanding clinician’s offices. The total payment rate is the national average rate and includes the program payment and beneficiary cost sharing.

Source: Analysis of Medicare physician fee schedule payment rates for 2021.

by outlier clinicians. The MACs could use their traditional tools for targeted review of providers, which include reviewing the medical records that support clinicians’ claims to determine whether they meet Medicare’s rules for billing, coverage, and medical necessity. If they do not, the MACs could deny these claims or seek to recover the payments if the claims have already been paid. Clinicians who primarily provide telehealth services—such as those who work for direct-to-consumer telehealth vendors—could be flagged as outliers more frequently than other clinicians. If so, their claims would be subject to additional

scrutiny but would not be denied if they meet Medicare’s requirements.

### **Require clinicians to provide a face-to-face visit before they order high-cost durable medical equipment or high-cost clinical lab tests**

Several companies that provide telehealth services have recently been involved in very large fraud cases, resulting in billions of dollars of losses for Medicare. The DOJ recently charged over 300 defendants with submitting more than \$6 billion in false and fraudulent claims to

federal health programs and private insurers, including more than \$4.5 billion related to telemedicine (Department of Justice 2020). Executives of telehealth companies allegedly paid physicians and nurse practitioners (NPs) to order unnecessary DME, genetic tests, other diagnostic tests, and pain medication without interacting with patients or with only a brief telephone conversation with patients they had never met. These companies then sold the orders from physicians and NPs to DME companies, laboratories, and pharmacies, which in turn submitted fraudulent claims for these items and services to Medicare and other government insurers.

In a previous enforcement action—Operation Brace Yourself—federal investigators uncovered schemes in which DME companies allegedly paid illegal kickbacks and bribes to medical professionals working with telemedicine companies to order unnecessary back, shoulder, wrist, and knee braces for Medicare beneficiaries (Department of Justice 2019a). This second set of cases—which involved more than \$1.2 billion in losses—resulted in charges against executives of five telemedicine companies. In Operation Double Helix, federal law enforcement charged individuals associated with dozens of telemedicine companies and cancer genetic testing laboratories with fraudulently billing Medicare more than \$2.1 billion for cancer genetic tests (Department of Justice 2019b). In several of these cases, physicians working for telemedicine companies allegedly ordered unnecessary cancer genetic tests for patients, even though they did not treat or speak with these patients.

If Medicare’s temporary expansion of coverage for telehealth services becomes permanent, there is a risk that such fraudulent schemes could become more common. A major concern is that telehealth arrangements make it easier to carry out fraud on a large scale because clinicians can speak with many beneficiaries from many parts of the country in a short amount of time, and beneficiaries do not need to see a clinician in person to receive an order for DME items or lab tests.

To protect the Medicare program and beneficiaries, CMS should, after the PHE, require clinicians to provide a face-to-face, in-person visit with a beneficiary on the date that they order a high-cost DME product or a high cost lab test for that beneficiary or within six months before such date. This approach—which was described in a prior Commission report—would prevent clinicians from ordering expensive DME items or lab tests during a

telehealth visit (Medicare Payment Advisory Commission 2018a). It would help ensure that a beneficiary needs a product or test based on a needs assessment conducted by a clinician before Medicare pays for it. CMS currently requires an in-person or telehealth visit for some DME items, such as certain hospital beds, but not for others (e.g., knee or back braces), and there is no such requirement for lab tests. To meet the current requirement for certain DME items, a clinician must have had an in-person or telehealth encounter with the beneficiary on the date the DME product was ordered or within six months before such date. The safeguard that we are proposing differs from the current policy because our approach would require an in-person visit while the current policy requires an in-person or telehealth visit. In addition, our proposal would apply to high-cost DME items and high-cost lab tests, whereas the current policy applies only to certain DME items.

### **Prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly**

Under certain conditions, Medicare pays for services that are billed by physicians and certain other clinicians but performed by nonphysician staff such as registered nurses (RNs), medical assistants, technicians, physician assistants (PAs), advanced practice registered nurses (APRNs), and physical therapists. These services are called “incident to” services. Examples of these services include Part B drugs administered in a physician’s office by a nurse, therapeutic exercises provided by a physical therapist in a physician’s office, and venipuncture (blood drawn for a laboratory test) performed by a medical assistant. Medicare’s “incident to” rules are complex and apply only to services furnished to certain patients (e.g., established patients who are not being treated for a new problem) and in nonfacility settings (e.g., clinicians’ offices) (Medicare Payment Advisory Commission 2019). In addition, “incident to” services usually require the direct supervision of a clinician, which means that the billing clinician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. The “incident to” rules allow clinicians to bill for services performed by any staff, whether they are licensed or unlicensed.

Little information exists regarding the types of “incident to” services received by beneficiaries, the types of nonphysician staff who provide them, and the quality of

these services. Medicare claims do not contain information on whether a service is billed as an “incident to” service. In one of the few studies of these services, OIG examined services billed by a sample of physicians in 2007 who appeared to bill for “incident to” services (Office of Inspector General 2009).<sup>12</sup> OIG found that half of these services were not personally performed by a physician and that unqualified nonphysicians, such as nurses and medical assistants, performed 21 percent of the services that physicians did not personally perform.<sup>13</sup> Services performed by unqualified individuals ranged from venipuncture to surgical procedures such as complex skin surgery.

In 2019, the Commission recommended eliminating “incident to” billing for APRNs and PAs and requiring these clinicians to bill Medicare directly (Medicare Payment Advisory Commission 2019). This change would increase transparency about the services delivered by APRNs and PAs. It would improve Medicare’s ability to identify and support clinicians providing primary care. It also would reduce Medicare spending because Medicare pays 85 percent of the PFS rate for services that are billed directly by APRNs and PAs, compared with the full PFS rate for “incident to” services. This recommendation did not apply to other individuals who may provide services under “incident to” rules, such as nurses, medical assistants, and physical therapists.

The Commission supports expanding its earlier recommendation to prohibit “incident to” billing for services provided by APRNs and PAs by applying it to telehealth services performed by *any* clinician who can bill Medicare directly. In addition to APRNs and PAs, physical therapists, occupational therapists, licensed clinical social

workers, registered dietitians, nutrition professionals, speech–language pathologists, and clinical psychologists are able to bill Medicare directly and are allowed to bill Medicare for telehealth services during the PHE (Centers for Medicare & Medicaid Services 2020d). Expanding our earlier recommendation would mean that any clinician who is able to bill Medicare directly would have to bill under their own national provider identifier (NPI) when they deliver a telehealth service to a beneficiary after the PHE.<sup>14</sup>

Expanding the Commission’s earlier recommendation would accomplish two objectives. First, it would provide Medicare with more information about the types of providers and the specific clinicians who deliver telehealth services to beneficiaries, which would help CMS ensure that beneficiaries are receiving high-quality, appropriate care. Second, it would enable CMS to better monitor the use of telehealth services to prevent overuse. Under the current “incident to” rules, it is difficult for CMS to determine whether an individual clinician is providing an excessive number of telehealth services because multiple individuals could be billing for these services under the clinician’s NPI. If, however, CMS required clinicians who can bill Medicare directly for telehealth services do so under their own NPI, the agency could more easily identify outlier clinicians.

Such a policy change would not apply to clinical staff, such as RNs and medical assistants, who are not able to bill Medicare directly for telehealth services. In addition, this change would not affect the delivery of care to beneficiaries. It would change only how certain providers bill Medicare. ■

## Medicare coverage and payment for telehealth services prior to the coronavirus public health emergency

**M**edicare pays separately for telehealth services provided by clinicians under the physician fee schedule (PFS). Before the coronavirus public health emergency (PHE), Medicare generally covered a limited set of telehealth services in rural locations under the PFS.<sup>15</sup> Under Medicare’s prospective payment systems (e.g., for inpatient hospitals and home health agencies), providers have the flexibility to use telehealth as part of an episode of care (e.g., a hospital admission), but because providers are paid on a per diem or per episode basis, the use of telehealth does not affect Medicare’s payments.<sup>16</sup> Under the Medicare Advantage (MA) program, payments to plans are capitated. Plan coverage must include the telehealth services covered under the PFS, but plans are also allowed to cover electronic delivery of any Part B service as part of the basic Medicare benefit.

### Payment for telehealth under Medicare’s prospective payment systems

Under Medicare’s prospective payment systems (including payment systems for inpatient and outpatient hospitals, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, long-term care hospitals, outpatient dialysis providers, home health agencies, and hospices), providers have the flexibility to use telehealth to deliver care if they believe it will improve patient outcomes or help keep costs below the applicable payment amount. These payment systems differ from the PFS because providers receive a fixed payment for all services delivered per day or during an episode of care. For example, hospitals can use telehealth technology to remotely monitor and treat patients in the inpatient intensive care unit, but they do not receive an additional payment for the use of telehealth technology. Clinicians are paid separately under the PFS for services they provide in hospitals, SNFs, and other facilities.

### Payment for telehealth under the physician fee schedule

The Social Security Act specifies that Medicare cover a limited set of telehealth services and modalities under

the PFS, and only in specified settings in rural locations (with certain exceptions).<sup>17</sup> For most telehealth services, the patient must be located at an “originating site” in a rural area, defined as rural health professional shortage areas or a county outside of a metropolitan statistical area, and the clinician must be located at a “distant site” in any location. Originating sites include physicians’ offices, hospitals, critical access hospitals, rural health centers, SNFs, federally qualified health centers, community mental health centers, and hospital-based dialysis facilities.<sup>18</sup>

Many covered telehealth services are defined in statute, but CMS has also expanded coverage to some services through regulation. Covered telehealth services include general health care services (e.g., evaluation and management (E&M) visits and annual wellness visits) and those related to kidney disease, behavioral health, substance use disorders, nutrition therapy, pharmacological management, stroke, and cardiovascular disease.<sup>19</sup> Under the PFS, providers billing for transitional care management services or chronic care management services may use telehealth technology, such as telephone calls or emails, to provide this care. However, the payment for the use of telehealth is part of the monthly payment for these services.<sup>20</sup>

Prior to the PHE, CMS began covering other remote services that, according to the agency, do not meet the statutory definition of “telehealth.” These services include:

- virtual check-ins, in which a patient checks in briefly with a clinician by telephone or other telecommunications device to decide whether an office visit is needed;
- clinicians’ remote evaluation of images or recorded videos sent to them by a patient and follow-up with the patient;
- remote monitoring and interpretation of physiological data (e.g., weight, blood pressure, pulse oximetry, and glucose monitoring) that are digitally stored and/or transmitted to a clinician;

*(continued next page)*

## Medicare coverage and payment for telehealth services prior to the coronavirus public health emergency (cont.)

- interprofessional consultations, in which a consulting clinician provides an opinion or advice to the patient’s treating clinician via telephone, internet, or electronic health record, without the need for face-to-face contact with the patient; and
- online digital evaluation services (e-visits), which are non-face-to-face patient-initiated communications with a clinician using an online patient portal (Centers for Medicare & Medicaid Services 2019, Centers for Medicare & Medicaid Services 2018).

Because these services do not meet the statutory definition of telehealth, CMS does not consider them subject to the geographic limits on where patients can be located. Consequently, Medicare pays for these services regardless of the patient’s location. However, because these services involve the exchange of medical information from one site to another through electronic communications, we consider them telehealth for the purpose of this chapter.

### Payment for direct-to-consumer services

Most telehealth services covered under the PFS are direct-to-consumer services, such as routine E&M visits and mental health visits. The originating site receives a \$27 telehealth facility fee payment, and the clinician at the distant site receives the usual PFS payment rate based on the type of service provided (e.g., an E&M office/outpatient visit).<sup>21</sup> Prior to the PHE, CMS paid providers for distant-site telehealth services at the PFS facility-based payment rate instead of the higher PFS nonfacility (office-based) rate.<sup>22</sup> Beneficiary cost-sharing responsibilities for telehealth services are the same as for other Part B services, although clinicians may reduce or waive cost sharing during the PHE.

### Payment for interprofessional consultations

Interprofessional consultations involve two payments. The treating clinician, who initiates the consultation, receives a flat payment amount and the consulting clinician receives an amount that varies based on the time involved. Clinicians are required to obtain beneficiary consent to furnish these services because beneficiaries are responsible for cost sharing.

### Payment for telehealth under Medicare Advantage

MA plans are required to cover all of the telehealth services covered in fee-for-service (FFS) Medicare, and they can offer telehealth services not covered under FFS Medicare as supplemental benefits (benefits that plans can provide in addition to the basic Medicare FFS benefit). Plans have offered a small number of supplemental telehealth benefits. For plan year 2017, CMS reported that 8 percent of plans covered remote patient monitoring services and 77 percent of plans covered “remote access technologies”—a broad category of services including email, two-way video, and nurse call-in telephone lines (Centers for Medicare & Medicaid Services 2016).

Starting in 2020, MA plans are allowed to cover electronic delivery of any Part B service as part of the basic Medicare benefit (these telehealth benefits are included in plans’ bids and are not treated as supplemental benefits) and can include access to telehealth from an enrollee’s home. The scope of telehealth coverage is determined by each plan’s benefit package. CMS’s temporary expansions of telehealth coverage in FFS Medicare during the PHE also apply to coverage through MA plans. ■

## Endnotes

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- 1 Medicare pays for certain 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 six 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.
- 2 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 PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of the coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 3 Primary care services include the following PFS services: office/outpatient 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.
- 4 CMMI has statutory authority to waive most of Medicare’s statutory requirements to test alternative payment models. Next Generation ACOs bear two-sided risk and have prospective beneficiary assignment.
- 5 Most ACOs did not adopt this waiver because they lacked the appropriate staff, technology, and provider buy-in.
- 6 CMS has statutory authority to waive many of Medicare’s requirements for MSSP ACOs.
- 7 Certain services, such as remote monitoring and interpretation of physiological data, are exceptions to this policy because CMS sets a single rate for each of these services because they are provided only remotely. Therefore, their payment rates have not changed during the PHE.
- 8 This policy applies to beneficiaries of Medicare and other federal health programs.
- 9 The 2020 nonfacility payment rate for electrocardiogram complete (Current Procedural Terminology (CPT) code 93000) was \$17.32, and the rate for electrocardiogram report (CPT code 93010) was \$8.66.
- 10 Many services, such as E&M visits, are based on the estimated amount of time (or range of time) that clinicians spend providing the service. Under the current “incident to” rules, it is difficult for CMS to determine the number of services personally performed by an individual clinician because multiple individuals may be performing those services but billing under the clinician’s national provider identifier (NPI). If, however, CMS requires that clinicians who are able to bill Medicare directly for telehealth services do so under their own NPIs, it would be easier for the agency to determine the number of services performed by each clinician.
- 11 For example, Medicare pays for the cost of services provided in hospital outpatient departments through the hospital outpatient prospective payment system.
- 12 OIG’s sample included physicians who billed Medicare for more than 24 hours of services in a day; OIG assumed that these physicians were more likely to have billed for services provided by other individuals.
- 13 Unqualified nonphysicians did not possess the necessary licenses or certifications, had no verifiable credentials, or lacked the training to perform the service.
- 14 Physical therapists, occupational therapists, and speech language pathologists are able to bill directly for telehealth services during the PHE under a waiver established by CMS. Unless CMS extends this waiver after the PHE, these clinicians would no longer be able to bill directly for telehealth services. In addition, under the Commission’s policy option, these clinicians would no longer be able to perform telehealth services that are billed as “incident to” services by other clinicians because such “incident-to” billing would be prohibited after the PHE.
- 15 Section 1834(m) of the Social Security Act specifies telehealth coverage under FFS Medicare and the PFS. The law specifies the permitted originating sites, authorized practitioners, and geographic location restriction to patients in rural areas. In the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and the Coronavirus Aid, Relief, and Economic Security Act of 2020, the Congress allowed CMS to waive all the restrictions

on telehealth, including the originating site and geographic location restrictions, during the PHE.

- 16 In addition to the areas of the Medicare program mentioned here, there is limited coverage of telehealth services under Medicare Part D. Section 10328 of the Affordable Care Act requires prescription drug plan sponsors to offer, at a minimum, an annual comprehensive medication review that may be furnished person to person or through telehealth technologies.
- 17 Section 1834(m) of the Social Security Act defines telehealth services as “professional consultations, office visits, and office psychiatry services” plus any other services specified by the Department of Health and Human Services. The statute limits Medicare’s coverage of telehealth to live two-way video, with one exception: It permits asynchronous store-and-forward technology (e.g., emailing a saved diagnostic image or video) in Medicare demonstrations in Alaska and Hawaii.
- 18 Clinicians are not required to be present at the originating site with the beneficiary unless it is medically necessary.
- 19 The Bipartisan Budget Act of 2018 expanded the coverage of telehealth services to include the treatment of stroke in hospitals located in urban areas and services for patients with end-stage renal disease who receive home dialysis in urban areas. The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 allowed coverage of telehealth services for the treatment of substance use disorders in urban areas and in patients’ homes. In the Consolidated Appropriations Act, 2021, the Congress gave the Secretary the authority to allow beneficiaries to receive mental health services through telehealth from the beneficiary’s home and outside of rural areas. The beneficiary must be seen at least once in person by the practitioner during the six-month period prior to the first telehealth service and other time periods as determined by the Secretary.
- 20 Providers who bill for a transitional care management service must have interactive contact with the beneficiary, such as a phone call or email, within two business days following the beneficiary’s discharge from an institutional setting. Clinicians who bill for a chronic care management services must provide enhanced opportunities for patients to communicate with clinicians by telephone, secure messaging, email, or electronic patient portal.
- 21 A critical access hospital may also receive payment as a distant site.
- 22 Under the PFS, the payment rate is based on three RVU components: work, practice expense, and professional liability insurance. When a service is performed in a facility (e.g., hospital outpatient department or skilled nursing facility), the practice expense amount is lower because the clinician does not incur costs for overhead, staff, equipment, and supplies. These costs are incurred by the facility, and Medicare pays for them under a different payment system. By contrast, when a service is delivered in a nonfacility setting (e.g., a clinician’s office), the practice expense amount is higher to account for the cost of overhead, staff, equipment, and supplies. The work component amount is the same regardless of setting.

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