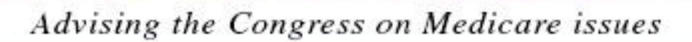

Telehealth in Medicare after the public health emergency

Ariel Winter and Ledia Tabor

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Context: Medicare has rapidly expanded telehealth during the public health emergency (PHE)

- Providers have rapidly adopted telehealth during the PHE
- Advocates assert that telehealth can expand access to care and reduce costs relative to in-person care
- Others contend that telehealth services have the potential to increase use and spending under a FFS payment system
- Telehealth has recently been implicated in several fraud cases
- Current evidence on how telehealth services impact quality of care is limited and mixed

Policy option for telehealth after the PHE

- Policy option for making some expansions permanent for all FFS clinicians after the PHE
  - Balance beneficiary choice and access with protecting program integrity
  - Assumes that policymakers will continue to gather more information about telehealth during the PHE
- CMS has authority to offer waivers to clinicians participating in advanced-alternative payment models

Policy option: Cover certain telehealth services provided to all beneficiaries and to beneficiaries at home

Pre-PHE	Beneficiaries in rural areas and certain originating sites
During the PHE	All beneficiaries and in beneficiaries' homes
Post-PHE	All beneficiaries and in beneficiaries' homes

Rationale

- Clinicians and beneficiaries in focus groups supported expanded access to telehealth visits with some combination of in-person visits
- Commissioners discussed that beneficiaries with chronic conditions, who constitute most Medicare beneficiaries, could benefit from at-home telehealth visits
- Direct-to-consumer telehealth companies would be able to bill for telehealth services for new and established patients, which can improve access but raises concerns about care fragmentation

Note: PHE (public health emergency). Illustrative option; for discussion purposes only.

Policy option: Cover additional telehealth services when they meet CMS's criteria for an allowable telehealth service

Pre-PHE	Medicare paid for about 100 telehealth services
During the PHE	Medicare added about 140 additional services (e.g., emergency department visits)
Post-PHE	Revert to review process to decide whether to cover a telehealth service

Rationale

- CMS has established criteria and a process to decide whether a service should be payable as a telehealth service
- CMS will pay for some telehealth services through the end of 2021 to allow the gathering of evidence of potential clinical benefit
- CMS criteria could be improved to explicitly consider how adding the service to the list affects program spending

Note: PHE (public health emergency). Illustrative option; for discussion purposes only.

Policy option: Cover certain telehealth services when provided by audio-only interaction if they offer clinical benefit

Pre-PHE	Telehealth services must include audio and video communication
During the PHE	Medicare pays for certain telehealth services when provided by audio-only interaction
Post-PHE	Audio-only interaction would be allowable for certain telehealth services if CMS determines it offers clinical benefit

Rationale

- Improve beneficiary choice and access to care, particularly for beneficiaries who do not have access to technology for a telehealth visit
- To evaluate clinical benefit, CMS should use a process similar to the one it uses to determine whether to pay for a telehealth service

Note: PHE (public health emergency). Illustrative option; for discussion purposes only.

Policy option: Cover audio-only E&M visits or virtual check-ins for established patients

Pre-PHE	Cover virtual check-in (5-10 minutes) between clinician and established patients
During the PHE	Added new audio-only E&M codes
Post-PHE	Cover audio-only E&M or virtual check-ins for established patients

Rationale

- Commissioners supported covering audio-only E&M or virtual check-in visits with established patients to improve beneficiary choice and access. These services would not go through the CMS review process.
- Audio-only visits with *established* patients assumes access to previous medical history and diagnosis from previous in-person or telehealth service
- These services should not be covered if they originate from a related E&M service provided within the previous 7 days or lead to an E&M service or procedure within the next 24 hours or soonest available appointment

Note: PHE (public health emergency), E&M (evaluation and management).
Illustrative option; for discussion purposes only.

Policy option: Pay lower rates for telehealth services than for in-person services

Pre-PHE	Paid the PFS facility rate for telehealth services (less than the in-office PFS rate)
During the PHE	Pays either the facility or in-office rate (based on where the service would have been provided)
Post-PHE	Pay less for telehealth services than in-person services, and pay less for audio-only services than telehealth services

Rationale

- Telehealth services probably involve lower practice costs than in-office services (lower costs for physical space, supplies, equipment, staff time)
- Paying same rates for telehealth and in-office services could distort prices and lead clinicians to favor telehealth services over in-person services
- Pay lower rates for audio-only services than telehealth services because they don't require video technology

Note: PHE (public health emergency), PFS (physician fee schedule). Illustrative option; for discussion purposes only.

Policy option: Require beneficiary cost sharing for telehealth services

Pre-PHE	Same cost sharing for telehealth services as in-person services
During the PHE	Clinicians permitted to reduce or waive cost sharing for telehealth services
Post-PHE	Same cost sharing for telehealth services as in-person services

Rationale

- Requiring beneficiaries to pay a portion of the cost of telehealth services could reduce possibility of overuse
- Telehealth services have a higher risk of overuse than in-person services because they are more convenient

Note: PHE (public health emergency). Illustrative option; for discussion purposes only.

Policy option: Other safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud

Safeguard	Rationale
Apply additional scrutiny to outlier clinicians who bill many more telehealth services than other clinicians	• Could also scrutinize clinicians who bill for a very high number of services in a week or a month (if total time spent providing telehealth > total number of hours in a week or a month) • Targeted review of claims billed by outlier clinicians (e.g., examine medical records to ensure claims meet billing rules)
Require clinicians to provide an in-person visit before they order high-cost DME and clinical lab tests	• Some telehealth companies have been implicated in large fraud cases involving unnecessary DME, genetic tests, and pain medication • Clinicians would not be able to order expensive DME or lab tests during telehealth visits

Note: DME (durable medical equipment). Illustrative option; for discussion purposes only.

Policy option: Other safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud, cont.

Safeguard	Rationale
Prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly	• “Incident to” billing: Medicare pays full rate for services billed by physicians but performed by other individuals • Any clinician who can bill Medicare directly would have to bill under their own billing number when performing a telehealth service • Expands on our prior recommendation on “incident to” services (2019) • Would give CMS more information about the clinicians who provide telehealth and help CMS prevent overuse

Note: Illustrative option; for discussion purposes only.

Policy option: Other safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud, cont.

Safeguard	Rationale
Require clinicians who bill "incident to" services to provide direct supervision in person instead of virtually	• Current rule: Billing clinician must provide *direct supervision* for "incident to" services (must be present in office suite and immediately available to furnish assistance and direction) • But CMS allows clinicians to provide direct supervision *virtually* instead of in person until 12/31/21 (or end of year in which PHE ends) • Virtual supervision could pose safety risk to beneficiaries because clinician is not physically available to provide assistance • Virtual supervision could enable a clinician to supervise multiple individuals in multiple settings simultaneously, raising safety and cost concerns

Note: PHE (public health emergency). Illustrative option; for discussion purposes only.

Discussion: Policy option for permanent telehealth expansion after the PHE

- Cover certain telehealth services provided to all beneficiaries and to beneficiaries at home
- Cover additional telehealth services when they meet CMS's criteria for an allowable telehealth service
- Cover certain telehealth services when provided by audio-only interaction if they offer clinical benefit
- Cover audio-only E&M visits or virtual check-ins for established patients
- Pay lower rates for telehealth services than for in-person services
- Require cost sharing for telehealth services
- Other safeguards to protect Medicare and beneficiaries
  - Apply additional scrutiny to outlier clinicians
  - Require clinicians to provide an in-person visit before ordering costly DME and lab tests
  - Prohibit "incident to" billing for telehealth services provided by any clinician who can bill Medicare directly
  - Require clinicians who bill "incident to" services to provide direct supervision in person instead of virtually

Note: Illustrative option; for discussion purposes only.