MEDPAC

Advising the Congress on Medicare issues

Medicare and telehealth: Assessing the current state of evidence and shaping future policies

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MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 Commissioners selected by the Comptroller General of the Government Accountability Office (GAO) for experience and subject matter expertise
  - Include providers, payers, researchers, beneficiary-focused individuals
  - Serve 3-year terms, can be reappointed
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields
- Seven public meetings during the year
  - Staff present analyses informed by site visits, focus groups with beneficiaries and providers, expert panels, input from stakeholders, quantitative analyses

Presentation roadmap

1. Overview of Medicare's telehealth policies and trends in use
2. Clinicians providing only telehealth services
3. In-person requirements for telehealth visits
4. Opportunities for additional research from the community

Medicare's telehealth policies before and during the PHE

- Before the PHE, coverage of telehealth was discretionary in MA, two-sided ACOs, and some FFS payment systems
- But coverage was limited under the PFS, and use was very low
- During the PHE, Medicare temporarily expanded coverage of telehealth
- Congress extended many telehealth flexibilities until end of 2024
- Permanently covered tele–behavioral health services at home

Note: PHE (public health emergency), MA (Medicare Advantage), ACO (accountable care organization), FFS (fee-for-service), PFS (physician fee schedule).

Current Medicare payment rates for telehealth services

PFS

- Generally, the same as if the services were furnished in person

FQHC/RHC

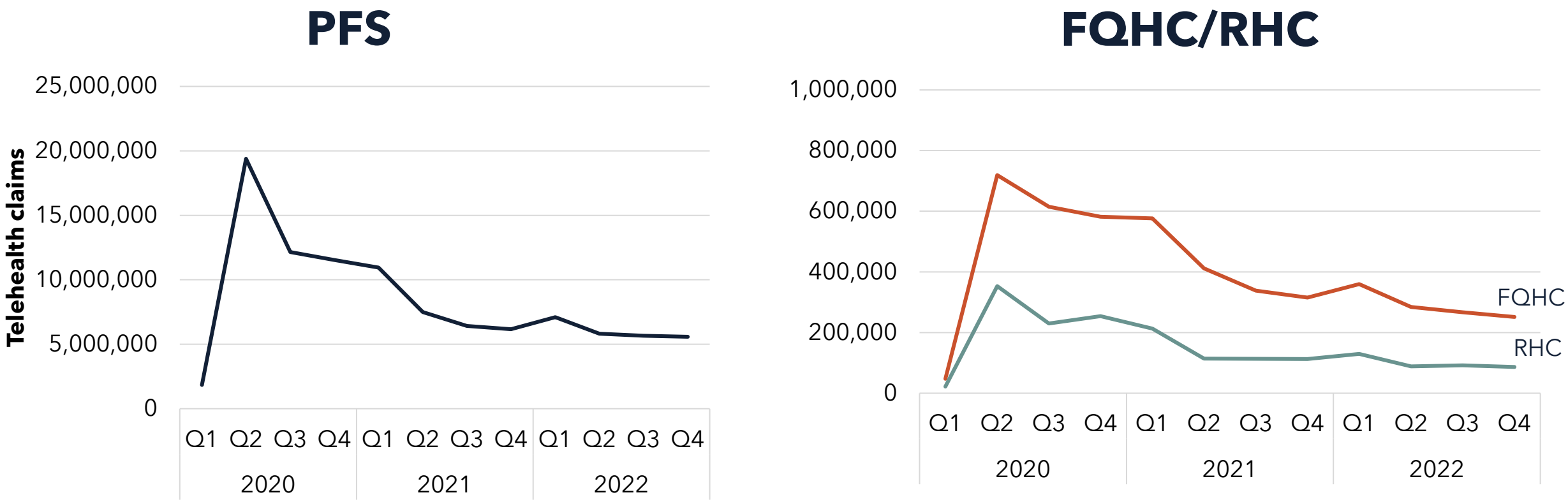
- Tele–behavioral health services: Same as if the service were furnished in person*
- Non–behavioral telehealth services: Set at the PFS-equivalent rate through 2024

*Medicare pays FQHCs and RHCs higher rates relative to the PFS

Note: PFS (physician fee schedule), FQHC (federally qualified health center), RHC (rural health clinic). In 2024, Medicare's FQHC base payment rate per visit is $195.99. The payment rate limit for most provider-based RHCs is based on each RHC's 2020 costs per visit, updated annually based on the Medicare Economic Index. In 2020, provider-based RHCs' average cost per visit was $255. In 2024, the payment rate limit for independent RHCs is $139. In 2024, the PFS-equivalent rate that FQHCs and RHCs receive for non–behavioral health telehealth visits is $95.27.

Source: Calendar year 2024 PFS final rule.

Telehealth use continued to decline in 2022



Note: PFS (physician fee schedule), FQHC (federally qualified health center), RHC (rural health clinic), Q (quarter).
Source: Analysis of Medicare claims data for 100% of FFS beneficiaries.

Share of claims with a telehealth service also continued to decline in 2022

Payment system	Share of claims with a telehealth service		
	2020	2021	2022
PFS	7.1%	4.7%	3.7%
FQHC	26.4	22.1	16.5
RHC	9.5	5.9	4.2

- FQHCs had a greater share of claims with a telehealth service than PFS or RHC claims did
- The share of PFS services delivered via telehealth varied by service type
  - 6% of common E&M office visits were delivered via telehealth
  - 50% of common psychotherapy services were delivered via telehealth

Note: PFS (physician fee schedule), FQHC (federally qualified health center), RHC (rural health clinic), E&M (evaluation and management). Examples use Healthcare Common Procedure Coding System (HCPCS) code 99214 (E&M office visit, established patient, 30–39 minutes) and HCPCS code 90837 (individual psychotherapy service, 60 minutes).

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

Beneficiaries and clinicians in focus groups had mixed reactions when asked about telehealth

- Some beneficiaries expressed hesitation about receiving care via telehealth because of limitations in what exams can take place virtually; other beneficiaries appreciated having telehealth as a convenient option in certain situations
- Beneficiary survey:
  - About 35% were interested in continuing to have the option of telehealth
  - About 90% of beneficiaries who had a telehealth visit were satisfied with the visit
- While acknowledging the value of telehealth to facilitate access, some clinicians raised concerns about what might be missed during telehealth visits, where examinations are limited

Note: The focus groups and survey of beneficiaries were conducted in 2023. Survey respondents were ages 65 and older. We annually conduct focus groups with beneficiaries and clinicians in different parts of the country to provide more qualitative descriptions of beneficiary and clinician experiences with the Medicare program.

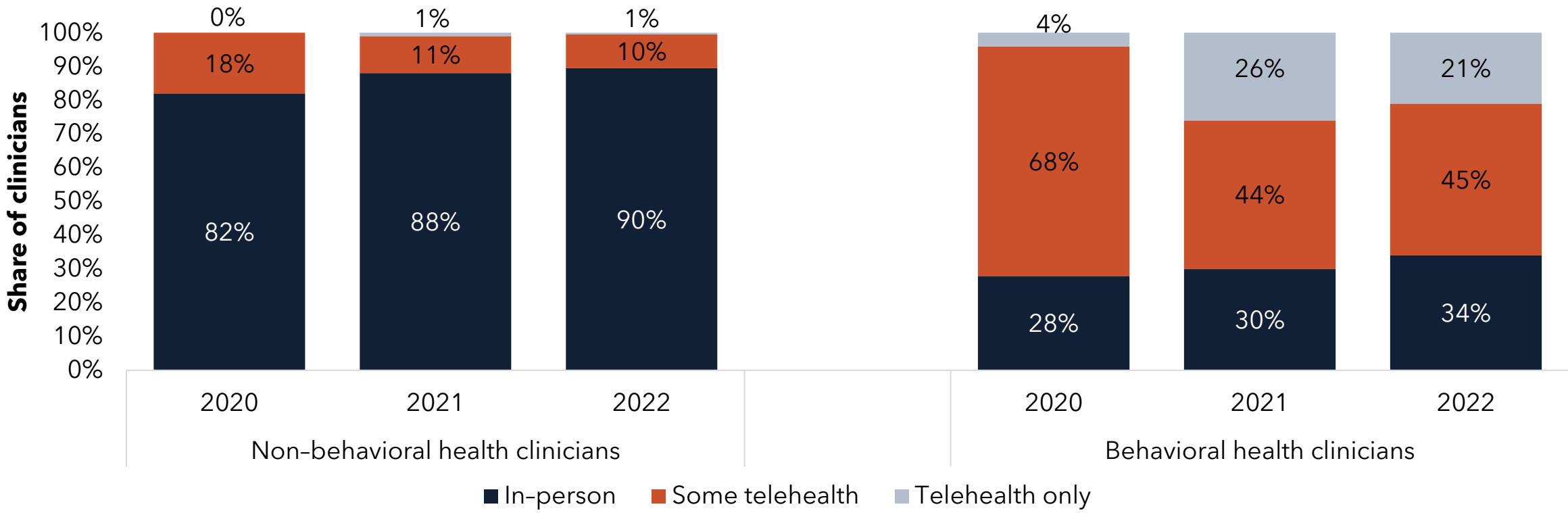
Source: NORC report for MedPAC, "Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2023 focus groups in select states," and MedPAC survey of beneficiaries, 2023.

Clinicians who provide only telehealth services

Are clinicians providing only telehealth services?

- Under the temporary telehealth expansions, beneficiaries can receive telehealth services in their home instead of being required to receive the service at a health care facility
- Some have expressed concerns that this may lead to a proliferation of "telehealth-only" providers
  - Such providers may not incur the cost of maintaining an office or other items needed for in-person visits
  - If payment rates are not set appropriately, more clinicians could move to providing only telehealth services, which could jeopardize access to in-person care

Relatively few clinicians provided telehealth services exclusively, but trends differed for behavioral health, 2022



Note: Columns may not sum to 100% due to rounding. Includes clinicians who billed services for at least five unique fee-for-service (FFS) beneficiaries in the calendar year. "In-person only" clinicians had 0% to 10% of physician fee schedule (PFS) services that were for telehealth or digital health services in the calendar year. "Some telehealth" clinicians had 11% to 89% of PFS services that were for telehealth or digital health services in the year. "Telehealth-only" clinicians had 90% or more of PFS services that were for telehealth or other digital services in the calendar year. We set the threshold at 90% (instead of 100%) to allow for some services being miscoded and because some other services that we did not count as telehealth or other digital health services can be delivered without an in-person visit (e.g., chronic care management). Behavioral health clinicians were defined as national provider identifiers with specialties of psychiatry, general psychiatry, psychology (billing independently), clinical psychology, addiction medicine, licensed clinical social work, or neuropsychiatry.

Source: Analysis of Medicare claims data for 100% of FFS beneficiaries.

Vast majority of clinicians are providing some or all care in person

- Analysis based on a short period, but it is unlikely that telehealth flexibilities are substantially impeding access to in-person care
- Sizable share of behavioral health clinicians are telehealth-only providers
  - Likely have lower costs than those who maintain an office, but:
    - Reductions in costs are likely modest
    - Allowing telehealth-only services could improve access to behavioral health services, especially in areas with ongoing access issues
- Desire to balance maintaining access to in-person care and concerns about reducing payments for behavioral health services

In-person requirements for telehealth visits

In-person visit requirements for tele–behavioral health services

- Congress permanently covered tele-behavioral health services at home
- Requirement for an in-person visit with the clinician 6 months prior to initiating service to a beneficiary in their home, and again annually
  - Delayed until January 1, 2025
- CMS established flexibilities to recognize beneficiary preferences and access to in-person behavioral health care, such as:
  - Another clinician of the same specialty in the same group can provide in-person visit
  - Policy on subsequent in-person visit does not apply if risks and burdens of in-person visit outweigh the benefits
  - Certain established patients may not be required to have in-person visit

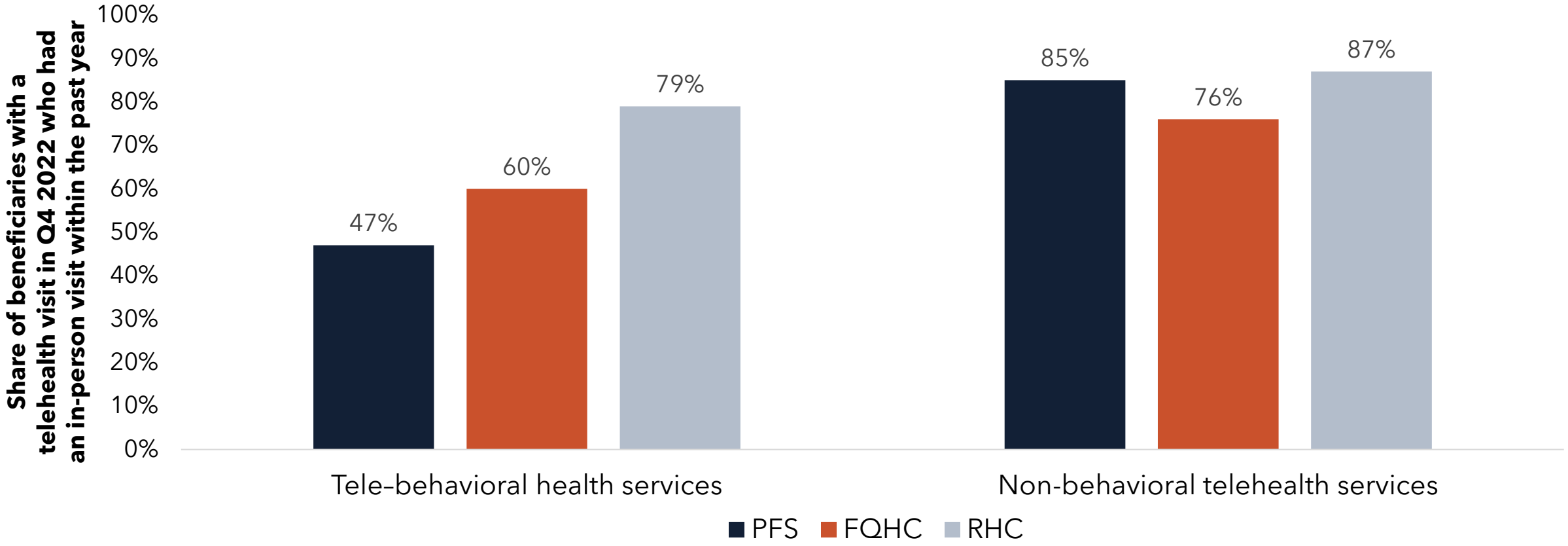
Note:: In the Consolidated Appropriations Act, 2021, Congress permanently covered tele-behavioral health services for beneficiaries at home.

What share of beneficiaries with a telehealth visit had an in-person visit within the preceding 12 months?

- Calculated the share of beneficiaries with a telehealth visit in the fourth quarter of 2022 who also had an in-person visit with the same provider group in the preceding 12 months
  - Stratified by PFS, FQHC, and RHC, as well as behavioral health and non–behavioral health services
- Consideration when reviewing results:
  - Flexibilities for in-person visits will apply in 2025

Note: PFS (physician fee schedule), FQHC (federally qualified health center), RHC (rural health clinic).

Almost half of beneficiaries with a tele–behavioral health visit under the PFS in Q4 2022 had a preceding in-person visit with that provider or one in the same group within the past year



Note: PFS (physician fee schedule), Q (quarter), FQHC (federally qualified health center), RHC (rural health clinic). A provider group is defined by tax ID for PFS claims and CMS Certification Numbers for FQHCs and RHCs.

Source: MedPAC analysis of PFS, FQHC, and RHC claims, 2021–2022.

Potential alternative safeguards

- Policymakers could consider alternative safeguards to protect Medicare and beneficiaries from unnecessary spending and potential abuses:
  - Apply additional scrutiny to outlier clinicians
  - Prohibit "incident to" billing for telehealth services provided by any clinician who can bill Medicare directly

Source: MedPAC's March 2021 and June 2023 reports to the Congress.

Opportunities for additional research from the community

- Assessment of trends and impacts on beneficiary access and quality with more recent data outside of the PHE
- Use of audio-only visits: Claims modifier required in 2023
- Inputs on provider costs to provide telehealth services

Note: PHE (public health emergency). The PHE ended on May 11, 2023.

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Questions or comments

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