Mandated report: Principles for evaluating the expansion of Medicare's coverage of telehealth services

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November 3, 2017

MEDPAC

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)

Presentation outline

- Definition of telehealth
- Comparison of Medicare and commercial plan telehealth coverage
- Principles for evaluating coverage expansions
- Examples by Medicare sector
  - Fee schedule for physicians and other health professionals (physician fee schedule or PFS)
  - Other fee-for-service (FFS) settings
  - ACOs and Medicare Advantage
- Discussion

Commission focusing on three types of telehealth

Direct-to-consumer (DTC)	Provider-to-provider (PTP)	Remote patient monitoring (RPM)
Patient-initiated telephone or two-way video virtual visits with clinicians from any location	A clinician at an originating site – in the presence of a patient – initiating communication with a clinical specialist at a distant site	A patient at home or a facility being monitored by a clinician from a remote location using two-way video or electronic device

Comparison of Medicare and commercial insurance plan coverage of telehealth services

	Medicare PFS	Commercial plans
Payment incentives	Taxpayers not indemnified against patient/provider volume incentives	Plans can use various tools to control volume incentives
Originating sites	Rural	Rural, urban, and patients' residence
Cost-sharing for telehealth	Equal to in-person services, but beneficiaries shielded by Medigap	Generally equal to or above in-person services
DTC services	No coverage	Common among several plans
RPM services	No coverage	Some plans testing
PTP services	Basic physician visits and mental health visits	
Experience to date	Low use and unclear outcomes	

	Other areas of Medicare	Commercial plans
Managed care plans	Extra telehealth benefits financed from rebates or supplemental premium	Telehealth benefits financed the same as other benefits
Testing/pilot programs	Some testing of telehealth as a part of larger payment models	Focused testing is common before implementation

MEDPAC Source: MedPAC review of Medicare and contractor survey of commercial plans

Principles for evaluating telehealth services under Medicare

Telehealth service should strike a balance between the three principles:

1. Access - Expand the availability of services or providers, facilitating a more timely delivery of care, and increasing convenience
2. Quality – Improve outcomes, patient experience, or value
3. Cost – Reduce cost for beneficiaries or the Medicare program

Medicare physician fee schedule (PFS)

- Volume incentives under the PFS may lead to misuse
- Limited policy tools to control volume incentives
- Exercise caution in considering telehealth expansion
- Evaluate the value of individual telehealth services using three principles
- Illustrative examples of how principles can be used to evaluate telehealth services

Illustrative example #1: Telestroke

- Background: Medicare PFS covers telestroke in rural areas, used by several health systems, commercial plans pay for it
- Policy option: Expand to urban originating sites
- Access: May enable more timely access to neurologists
- Quality: Expanded access may lead to quality improvement
- Costs:
  - Increase to program costs: more consults and other services
  - Increase mitigated by: Risk of misuse is low and potential for long-term savings from reducing disabilities

Illustrative example #2: Beneficiaries with physical-disabilities and treatment-intensive conditions

- Background: Some home health agencies and commercial plans use telehealth for patients with chronic conditions
- Policy options: Permit urban originating sites or the patient residence for patients with certain conditions
- Access: Patients with mobility limitations and a need for frequent visits may benefit from greater convenience
- Quality: Potential to improve patient adherence to treatment protocols, but evidence limited
- Costs:
  - Increase program costs: more visits
  - Increase mitigated by: limited population and implementing visit caps or prior authorization

Illustrative example #3: Tele-mental health services

- Background: Medicare PFS covers these services in rural areas, many commercial plans cover urban and rural areas
- Policy options: Expand to urban originating sites or the patient residence as originating site
- Access: Potential to expand access to clinicians where limited, increase convenience, and encourage patients to seek needed care
- Quality: Potential to improve timeliness, care coordination, and medication management, but evidence limited
- Costs:
  - Increase program cost: large pool of users and resulting visits
  - Increase mitigated by: implementing visit caps or prior authorization

Illustrative example #4: Direct-to-consumer (DTC) telehealth services

- Background: Not covered by Medicare, many commercial plans cover DTC using vendors or their own clinicians
- Policy option: Cover DTC services in urban and rural areas
- Access: Potential to expand access to clinicians and increase convenience for beneficiaries
- Quality: Potential to improve quality, but evidence unclear
- Costs:
  - Increase program cost: Routine services available to all beneficiaries, patient-initiated from any location, beneficiaries shielded from cost-sharing by supplemental insurance
  - Increase mitigated by: Implementing visit caps or prior authorization

Medicare PFS: Expand testing

- Expand testing efforts through CMMI for telehealth services where value is unclear, for example:
  - Direct-to-consumer services
  - Pharmacological management services in urban areas
  - Nursing home-based services in urban areas
  - Remote patient monitoring services for patients with chronic conditions

Other Medicare FFS payment settings

- Adequate flexibility to use telehealth already exists
- Providers can use telehealth if they believe it benefits patients or lowers their costs
- Telehealth services are contemplated in provider's fixed payments

Entities accepting financial risk under Medicare

- Entities bearing financial risk determine impacts of telehealth services on access, quality, and cost
- Two-sided ACOs:
  - Accept downside financial risk when beneficiary spending exceeds a benchmark
  - Currently have a waiver to use telehealth services covered under Medicare PFS in urban areas or patient's residence
  - Flexibility could be expanded to cover other telehealth services, not covered under the PFS

Policy options: Expanding telehealth coverage in MA

- Current telehealth coverage in MA
  - Must cover FFS Medicare services
  - May offer additional (supplemental) services
    - Financed by rebate or additional premiums
- Option 1: Expand telehealth in FFS
  - Effectively expands telehealth in MA
  - No change to MA program or payment policy
  - Basic Medicare benefit remains equivalent in MA and FFS

Policy options: Expanding telehealth coverage in MA

- Option 2: Allow MA plans to include telehealth services in their bid
  - Medicare payment for telehealth included in base payment, not rebate
  - Telehealth benefit would be mandatory for all plan members
  - Basic A & B benefit separable from telehealth component in bid
  - Basic Medicare benefit would differ for MA and FFS

Summary:

- Medicare covers telehealth in several settings
- Commercial plans coverage of telehealth varies
- Differences between telehealth coverage under Medicare PFS and by commercial plans reflect payment incentives
- Medicare PFS: Three principles can be used to evaluate the incorporation of telehealth services
  - Some services may add value greater than their potential costs
  - The value of others may be unclear and testing may be needed
- Entities bearing financial risk under Medicare (e.g., MA plans and two-sided ACOs) may warrant greater flexibility to cover telehealth

Discussion and next steps

- Discussion:
  - Structure of the report
  - Questions about material to date
  - Refinements to principles or conclusions

- Next steps:
  - January: Discussion of the full report
  - March 15, 2018: Report due to Congress