Telehealth services and the Medicare program

Zach Gaumer, Amy Phillips, and Ariel Winter

March 3, 2016

MEDPAC

Outline

- Review of November 2015 presentation
- New work for March 2016
- Updated definition of telehealth services
- New information: Medicare telehealth utilization
- Efficacy of telehealth services
- Discussion questions

Review of information from our November 2015 presentation

- Medicare covers limited set of telehealth services
  - Originating sites: Rural facilities receive $25 PFS facility fee
  - Distant sites: Clinicians in any location receive full PFS rates
- Medicare utilization low, but has grown rapidly
  - Physicians, NPs, and behavioral health clinicians
  - Physician offices, health centers, and hospitals
  - Disabled beneficiaries (61 percent)
  - Rural (58 percent) and urban (42 percent) beneficiaries
- Some employers and insurers offer telehealth
- VA uses telehealth more widely
- Evidence of the efficacy of telehealth is mixed

Research since November 2015 meeting

- Updated Medicare claims data analysis
- Assessment of MA and bundled payment models
- Structured interviews with insurers and VA
- Site visit
- Expanded literature review
- Meetings with several health systems, telehealth vendors, and advocates
- Evaluation of state and Medicaid policy

Most telehealth services fall into one of six different forms

Basic medical care and consultations:

1. Patient at home ➡ Clinician
2. Patient at medical facility ➡ Clinician
3. Clinician A ➡ Clinician B

Remote monitoring

4. Patient in the hospital
5. Patient at home

Store-and-forward transmission

6. Electronic transfer of patient data to a clinician

Source: MedPAC assessment of telehealth services

Use of telehealth services in Medicare in 2014

- Distant sites: Services received
  - Physician offices and health centers: E&M visits
  - Inpatient hospital departments: follow-up and ED visits
- Providers:
  - Small number use telehealth (1,400 originating, 3,300 distant)
  - Less than 1 percent accounted for 22 percent of visits
- Beneficiaries:
  - 69,000 beneficiaries: 3 visits and $182 per user
  - Dual-eligibles 61 percent of users, 67 percent of visits
  - 2 percent used more than 1 visit per month
- 55 percent of encounters had no originating site claim
- 6 percent of visits crossed state lines

Other Medicare coverage of telehealth services

- MA plans permitted to cover telehealth services
  - Fee schedule telehealth services included in plan bid amounts
  - Other telehealth services defined as supplemental benefits
  - Supplemental benefits financed through rebate dollars or beneficiary premiums
  - 8 percent of plans offer remote patient monitoring
- Some CMMI risk-based models allow use of telehealth
  - Next Gen ACOs & other models permit urban and/or home use
  - Health Care Innovation Awards: variety of small demonstrations
- Other fee schedule services: remote interpretation of imaging (volume unknown) and monitoring of cardiac patients and devices (900,000 beneficiaries and $189 million in 2014)

Use of telehealth services: Insurers

- Scope: Several national and regional insurers cover telehealth services
- Rationale: Enrollee convenience, clinician and employer requests
- Coverage: Primary care (after-hours); originating sites include home, urban, and rural
- Payment: Telehealth paid at same amount as face-to-face visits; prefer to pay for telehealth under capitation
- Cost-sharing: Varies

Use of telehealth services: Health systems

- Scope: Several health systems have developed telehealth products
- Rationale: Expand access and convenience, staffing efficiencies
- Services:
  - Hospital-based (e.g., tele-stroke, tele-ICU, and tele-hospitalist)
  - Basic medical care (e.g., case management and primary care)
- Capital investment: Moderate for systems, facilities, clinicians; federal grants available

Use of telehealth services: The Department of Veteran Affairs (VA)

- Scope: Telehealth programs operating for over a decade (736,000 veteran users)
- Rationale: Clinicians requested telehealth
- Coverage: Three nationwide programs in place
  - Clinical video telehealth: primary care and consults
  - Home telehealth: case management for chronic cases
  - Store-and-forward transmission: Imaging and specialty care
- Cost-sharing: Varies to encourage patients to use some forms of telehealth
- VA's unique characteristics:
  - Fully integrated system with a global budget payment model
  - Clinicians licensed by the VA across all VA facilities

State telehealth parity laws and coverage by Medicaid programs

- State telehealth parity laws: 28 states have telehealth/face-to-face payment parity with commercial insurance
- Medicaid programs: 49 Medicaid programs and Washington, D.C. cover telehealth to some degree, but coverage varies widely
- Clinicians must be licensed in each state, and licensure requirements vary by state

Evidence of efficacy of telehealth services is mixed

- Access and convenience: Several studies and stakeholders indicate telehealth services expand access and convenience
- AHRQ (2015): Meta-analysis of 44 telehealth studies
  - Quality of care: Evidence is mixed. Positive outcomes for patients with chronic conditions and behavioral health needs, but efficacy unclear for hospital-based, primary care, or shared-risk telehealth interventions.
  - Cost of care: Evidence is mixed. Cost reductions for certain forms of telehealth and for certain populations, but often do not include infrastructure cost
  - More large, targeted, unbiased studies needed

Medicare coverage of telehealth: FFS

- Medicare pays separately for each telehealth service under FFS
- As with any service under FFS, providers have incentive to increase use of telehealth regardless of impact on total spending
- If policymakers wish to expand coverage, could identify services with low potential for unnecessary use (e.g., tele-stroke)
- Commission discussed per member per month (PMPM) partial capitation payment for primary care, which could include telehealth

Medicare coverage of telehealth: Bundled payment and ACOs

- Bundled payment models from CMMI
  - Bundled Payment for Care Improvement Initiative, Comprehensive Care for Joint Replacement model
  - Providers have more flexibility to use telehealth but are at risk if total spending per episode exceeds the target
  - Providers have incentive to use telehealth if it reduces episode spending or improves quality
- ACOs
  - Next Generation ACOs (two-sided risk) are allowed to provide telehealth to patients in rural and urban areas and in their homes
  - Other ACOs do not have this waiver

Medicare coverage of telehealth: Medicare Advantage

- Current policy
  - Telehealth services covered by FFS Medicare are included in the plan bid amount
  - Supplemental telehealth services must be financed with rebate dollars or beneficiary premiums
- Allow plans to include supplemental telehealth services in bid?
  - Unclear if net bid would increase or decrease (depends on whether telehealth increases or decreases overall spending)
  - If bid is higher, would reduce rebate dollars and Medicare savings, and vice versa
  - MA benefit would no longer be comparable to FFS benefit
  - Sets a precedent for other services?
  - Secretarial determination?

Potential policy principles if telehealth coverage is expanded

- FFS
  - Cover services with low potential for unnecessary use (e.g., tele-stroke)?
  - Allow primary care providers to offer more telehealth under PMPM payment?
- Bundled payment/ACOs: Expand coverage if providers at risk for total spending for episode or population?
- MA: Allow plans to include supplemental telehealth services in bids?