Telehealth in Medicare after the public health emergency

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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

<table>
<thead>
<tr>
<th></th>
<th>Pre-PHE</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>During the PHE</td>
<td>Beneficiaries in rural areas and certain originating sites</td>
<td>• Clinicians and beneficiaries in focus groups supported expanded access to telehealth visits with some combination of in-person visits</td>
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<td>All beneficiaries and in beneficiaries’ homes</td>
<td>• Commissioners discussed that beneficiaries with chronic conditions, who constitute most Medicare beneficiaries, could benefit from at-home telehealth visits</td>
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<td>Post-PHE</td>
<td>All beneficiaries and in beneficiaries’ homes</td>
<td>• 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</td>
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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

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

**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

<table>
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<th>Pre-PHE</th>
<th>Cover virtual check-in (5-10 minutes) between clinician and established patients</th>
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<tbody>
<tr>
<td>During the PHE</td>
<td>Added new audio-only E&amp;M codes</td>
</tr>
<tr>
<td>Post-PHE</td>
<td>Cover audio-only E&amp;M or virtual check-ins for established patients</td>
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**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

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

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<th>Pre-PHE</th>
<th>Same cost sharing for telehealth services as in-person services</th>
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<tr>
<td><strong>During the PHE</strong></td>
<td>Clinicians permitted to reduce or waive cost sharing for telehealth services</td>
</tr>
<tr>
<td><strong>Post-PHE</strong></td>
<td>Same cost sharing for telehealth services as in-person services</td>
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#### 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

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<th>Safeguard</th>
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| 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.

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<td>Prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly</td>
<td>• “Incident to” billing: Medicare pays full rate for services billed by physicians but performed by other individuals&lt;br&gt;• Any clinician who can bill Medicare directly would have to bill under their own billing number when performing a telehealth service&lt;br&gt;• Expands on our prior recommendation on “incident to” services (2019)&lt;br&gt;• Would give CMS more information about the clinicians who provide telehealth and help CMS prevent overuse</td>
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Note: Illustrative option; for discussion purposes only.
Policy option: Other safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud, cont.

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| 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  |
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.