

# Telehealth: Updates on use, beneficiary and clinician experiences, and other topics of interest

Ariel Winter, Ledia Tabor, and Bhavya Sukhavasi

November 8, 2021

# Outline of presentation

---

- Review Medicare's expansion of telehealth during the public health emergency (PHE) and MedPAC's policy option
- Update on use of telehealth during PHE
- Beneficiary and clinician experiences with telehealth
- Findings from interviews with direct-to-consumer telehealth companies
- Tele-behavioral health
- Policy options to collect more data on use of telehealth

# Medicare's telehealth policies before public health emergency (PHE)

---

- Coverage of telehealth was flexible in Medicare Advantage, two-sided ACOs, other payment systems
- But coverage was limited under PFS
- Under PFS, Medicare paid for
  - Limited set of telehealth services
  - Provided in certain settings in rural areas (with some exceptions)
- Use of telehealth services was very low (<1% of PFS spending in 2019)

# During PHE, Medicare temporarily expanded coverage of telehealth services under the PFS

	Before the PHE	During the PHE
<b>Who can receive telehealth services?</b>	Clinicians can provide telehealth to beneficiaries in certain originating sites in rural areas (e.g., an office or hospital).	Clinicians may provide telehealth to beneficiaries in rural and urban areas, including patient's home.
<b>Which types of telehealth services does Medicare pay for?</b>	Limited set of services.	CMS pays for over 140 additional telehealth services and allows audio-only interaction for some services.
<b>How much does Medicare pay for telehealth services?</b>	PFS rate for facility-based services (less than the nonfacility rate).	PFS rate is the same as if the service were provided in person (facility or nonfacility rate, depending on clinician's location).
<b>What are the costs to beneficiaries?</b>	Standard cost sharing.	Clinicians permitted to reduce or waive cost sharing.

# MedPAC policy option for post-PHE telehealth: Temporarily continue certain expansions (March 2021)

---

- Medicare should continue certain telehealth expansions for a limited duration (e.g., one to two years after the PHE)
  - Pay for specified telehealth services provided to all beneficiaries regardless of their location
  - Cover selected telehealth services if there is potential for clinical benefit
  - Cover certain telehealth services when provided through an audio-only interaction if there is potential for clinical benefit
- Rationale: Allow policymakers to gather more evidence about the impact of telehealth on access, quality, and cost
- Evidence should inform permanent changes to Medicare's telehealth policies

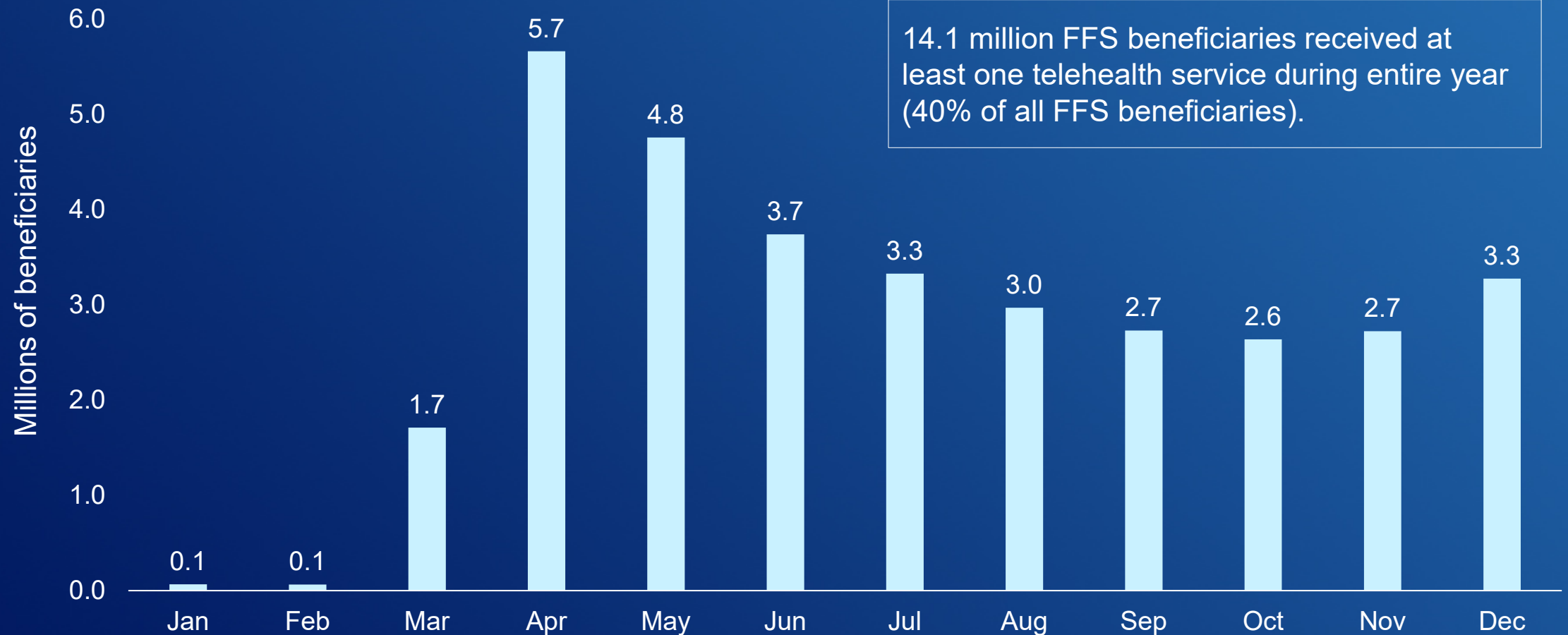


# MedPAC policy option for post-PHE: Return to some prior policies, add safeguards (March 2021)

---

- Medicare should return to paying the fee schedule's facility rate for telehealth services
- Providers should not be allowed to reduce or waive cost sharing for telehealth services
- Additional safeguards to protect Medicare and beneficiaries from unnecessary spending and potential fraud
  - Apply additional scrutiny to outlier clinicians
  - Require clinicians to provide an in-person, face-to-face visit before ordering costly DME and lab tests
  - Prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly

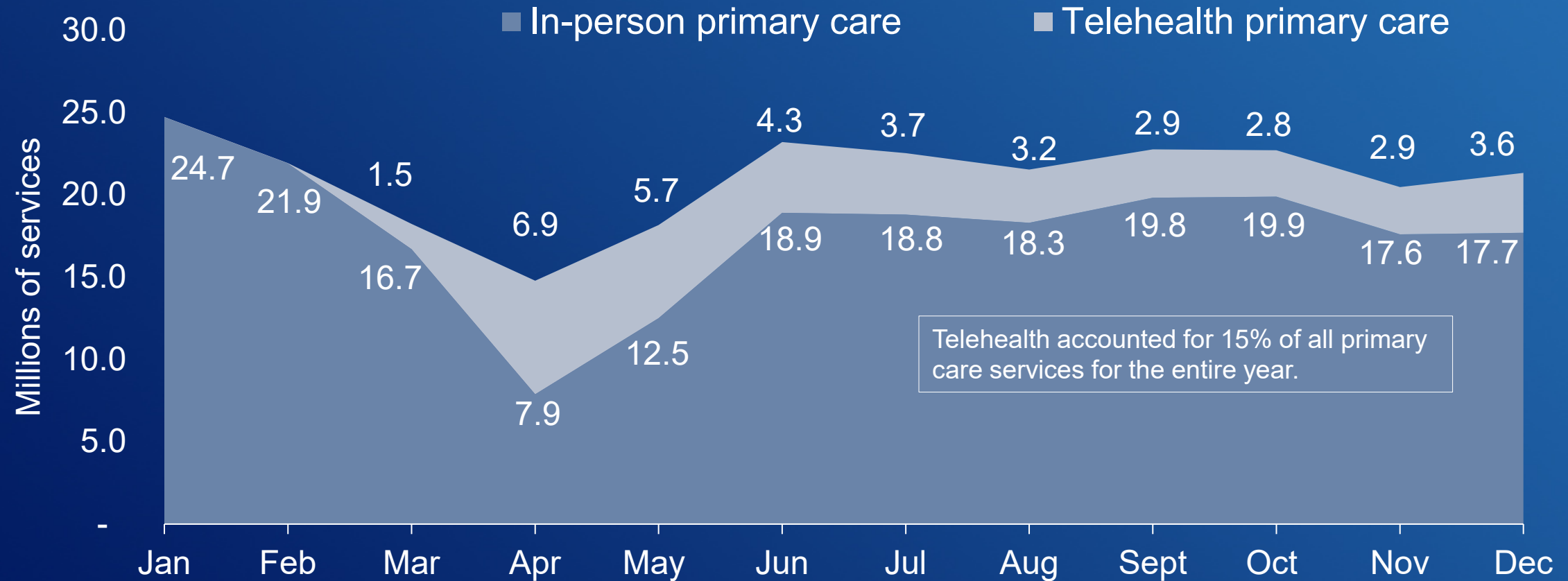
# Number of FFS beneficiaries who received at least one telehealth service by month, 2020



Note: FFS (fee-for-service).

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

# Telehealth accounted for almost half of all primary care services in April 2020, then declined to 17% in December



Note: Primary care services include the following physician fee schedule services: office/outpatient evaluation and management (E&M) visits, home E&M visits, E&M visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care), audio-only E&M visits, chronic care management, transitional care management, Welcome to Medicare visits, annual wellness visits, e-visits, and advance care planning services.

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

Data are preliminary and subject to change.



# Other findings from analysis of 2020 Medicare claims data

---

- E&M office/outpatient visits accounted for 72% of allowed charges for telehealth services (95% of these visits were for established patients)
  - Telephone E&M services accounted for 18% of allowed charges for telehealth services
- Mental, behavioral and neurodevelopmental disorders accounted for 25% of allowed charges for telehealth
- Number of telehealth services per beneficiary varied by geographic region, but changes in use of telehealth were similar across regions
- Certain groups of beneficiaries received more telehealth services per beneficiary than others: Under age 65, disabled, with end-stage renal disease, dually eligible beneficiaries, urban residents

Note: E&M (evaluation and management).

# Evidence from the literature on the use of telehealth during the PHE

---

- Reviewed peer-reviewed studies on the use of telehealth in the US during the PHE
- Main findings are consistent with the results of our claims analysis
  - Volume of telehealth services increased during the PHE
  - Mental health conditions accounted for a high share of telehealth services
  - Telehealth utilization varied among different groups of patients

# Beneficiary and clinician experiences with telehealth from our telephone survey and virtual focus groups

- Beneficiaries report telehealth visits mainly with clinicians with whom they have a relationship
- Beneficiaries are generally satisfied with telehealth visits
- Many clinicians reported that they continue to provide telehealth
  - Some clinicians appreciate the convenience and flexibility
  - Others preferred in-person visits due to perceived better quality of care or to provide procedures and testing
- Many beneficiaries and clinicians would like to continue the option of telehealth visits

# Findings from interviews with direct-to-consumer telehealth companies

---

- 4 of the 5 companies we interviewed do not bill FFS Medicare and do not plan to do so in the future
- Primary clients are health plans, large employers, and health systems
- Provide visits for mainly urgent, low-acuity care needs, and many of the companies offer tele-behavioral health visits
- A few are beginning to offer virtual primary care, but not yet focusing on elderly patients
- Companies varied in their arrangements with clinicians

# Tele-behavioral health

---

- Tele-behavioral health services include individual therapy, group therapy, and treatment for substance use disorders
- Telehealth services have played an important role in treating mental and behavioral health conditions during the PHE
- Literature before the PHE suggests that tele-behavioral health improves access, especially for beneficiaries facing barriers, and short-term outcomes are similar whether patients use telehealth or in-person care



# Permanent expansion of tele-behavioral health

---

- The Consolidated Appropriations Act, 2021 removed geographic restrictions and added the patient's home as an originating site for tele-behavioral health services
  - Requires that an in-person service be provided within 6 months prior to the initial telehealth service and at other intervals
- CMS's final PFS rule for 2022
  - Requires that an in-person service be provided 6 months prior to initial telehealth service and at least once every 12 months thereafter
  - Covers audio-only behavioral health services

# CMS does not collect data on certain telehealth services

---

- PFS audio-only telehealth services
  - Prior to the PHE, CMS only paid for telehealth services that used audio and video interaction
  - During the PHE, CMS pays for many telehealth services provided by audio only
  - For many services, there is no way to determine whether service was delivered by audio only, so it is difficult to assess their impact on access, quality and cost
- Home health agencies and hospices do not submit claims on telehealth visits

# Policy options to collect more data on the use of telehealth

---

- Require a claims modifier for audio-only telehealth services paid under the PFS
- Collect claims data on telehealth services provided by home health agencies and hospice providers

# Conclusion

---

- We plan to continue to monitor the use of telehealth, beneficiary and clinician experiences with telehealth, and the growing telehealth literature
- Discussion
  - Comments on materials?
  - Policy options to collect more data on the use of telehealth?
  - Other topics to explore?