Mandated report: Study on the expansion of telehealth

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September 29, 2022

Outline of presentation

- Mandated telehealth report
- Expansion of telehealth during PHE
- Commission's policy option for telehealth after PHE
- Medicare's permanent changes to telehealth policy since the PHE
- Analytic plan for mandated report
- Alternative approach to paying for telehealth services under the PFS
- Paying for telehealth services provided by FQHCs and RHCs

Note: PHE (public health emergency), PFS (physician fee schedule), FQHCs (federally qualified health centers), RHCs (rural health clinics).

CAA, 2022: Telehealth report due June 2023

- Use of telehealth services
- Medicare expenditures on telehealth
- Medicare payment policy for telehealth services and alternative approaches under the PFS and the payment systems for FQHCs and RHCs
- The impact of expanded telehealth coverage on access to care and quality
- Other areas

Note: CAA (Consolidated Appropriations Act), PFS (physician fee schedule), FQHCs (federally qualified health centers), RHCs (rural health clinics).

Medicare's telehealth policies before the PHE

- Coverage of telehealth was flexible in Medicare Advantage, two-sided ACOs, other payment systems
- But coverage was limited under the PFS
- Under the 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)

Note: PHE (public health emergency), ACOs (accountable care organizations), PFS (physician fee schedule).

At start of PHE, Medicare temporarily expanded coverage of telehealth services under the PFS

	Before the PHE	During the PHE
Who can receive telehealth services?	Beneficiaries in certain originating sites in rural areas (e.g., an office or hospital).	Beneficiaries in rural and urban areas, including patients' homes.
Which types of telehealth services does Medicare pay for?	Limited set of services. Must include audio and video technology.	CMS pays for over 140 additional telehealth services and allows audio-only interaction for some services.
How much does Medicare pay for telehealth services?	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).

Note: PHE (public health emergency), PFS (physician fee schedule). Under the PFS, clinicians who provide services in facilities such as hospitals receive a lower payment rate (the facility rate) than clinicians who provide services in offices (the nonfacility rate).

Commission's policy option for post-PHE telehealth

- 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

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Note: PHE (public health emergency).
Source: Medicare Payment Advisory Commission, 2021 (March).

Commission's policy option for post-PHE telehealth (cont.)

- Medicare should return to paying the physician 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

Note: DME (durable medical equipment).
Source: Medicare Payment Advisory Commission, 2021 (March).

Other changes to Medicare's telehealth polices since the start of the PHE

- Extended flexibilities for 5 months after the PHE
- Covered tele-behavioral health services at home
  - Requires in-person service to be provided within 6 months prior to the initial telehealth service and annually thereafter
- Extended the timeframe for covering some services provided by telehealth (until end of 2023)
- Proposal to require claims modifier for audio-only services, consistent with Commission recommendation (March 2022)

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Note: PHE (public health emergency).

Mandated report: Analyzing changes in telehealth volume and spending during PHE

- Use of telehealth by type of service
- Changes in number of beneficiaries who received telehealth during the PHE
- Regional variations in use of telehealth
- Use of telehealth by beneficiary characteristics
- Use of telehealth by beneficiaries who live in different states than their clinician
- Clinicians with very high use of telehealth services (outliers)

Note: PHE (public health emergency).

Mandated report: Assessing the impact of telehealth on access and quality

- Pre-pandemic literature and data are of limited use in understanding the impact of expanded telehealth
- Pandemic-era data may not be appropriate to use when analyzing the potential impact of telehealth policy outside of a pandemic
- Technical challenges:
  - Medicare lacks comprehensive data sources (e.g., lab results, patient-reported outcomes)
  - Time lag in administrative claims data

Using population-based outcome measures to assess the impact of telehealth expansion on access and quality

- Goal: To understand if beneficiaries having access to multiple modes of care (in-person, audio and video, audio only) has implications for quality outcomes, access, and cost
- Working with a contractor to test feasibility of using population-based measures to study impact of telehealth on access to and quality of care
  - We are currently developing methods to perform this analysis
  - More details will be provided in future meetings

Mandated report: Additional analyses

- Review the literature on impact of expanded telehealth coverage on use of services, access, and quality
- Focus groups with beneficiaries and clinicians
- Our annual survey of Medicare beneficiaries and privately insured individuals

Mandated report: Considering alternative approaches to paying for telehealth services under the PFS

- Problems with paying separately for each telehealth service
  - Incentive for clinicians to bill for more services
  - Increased administrative burden on clinicians because they need to document and bill for each service
  - Difficult to price individual telehealth services
- Option: Bundle telehealth services into a larger unit of payment instead of paying separately for each service
  - Create expanded E&M office/outpatient visit codes that include related telehealth and in-person services provided during a period of time (e.g., 30 days)

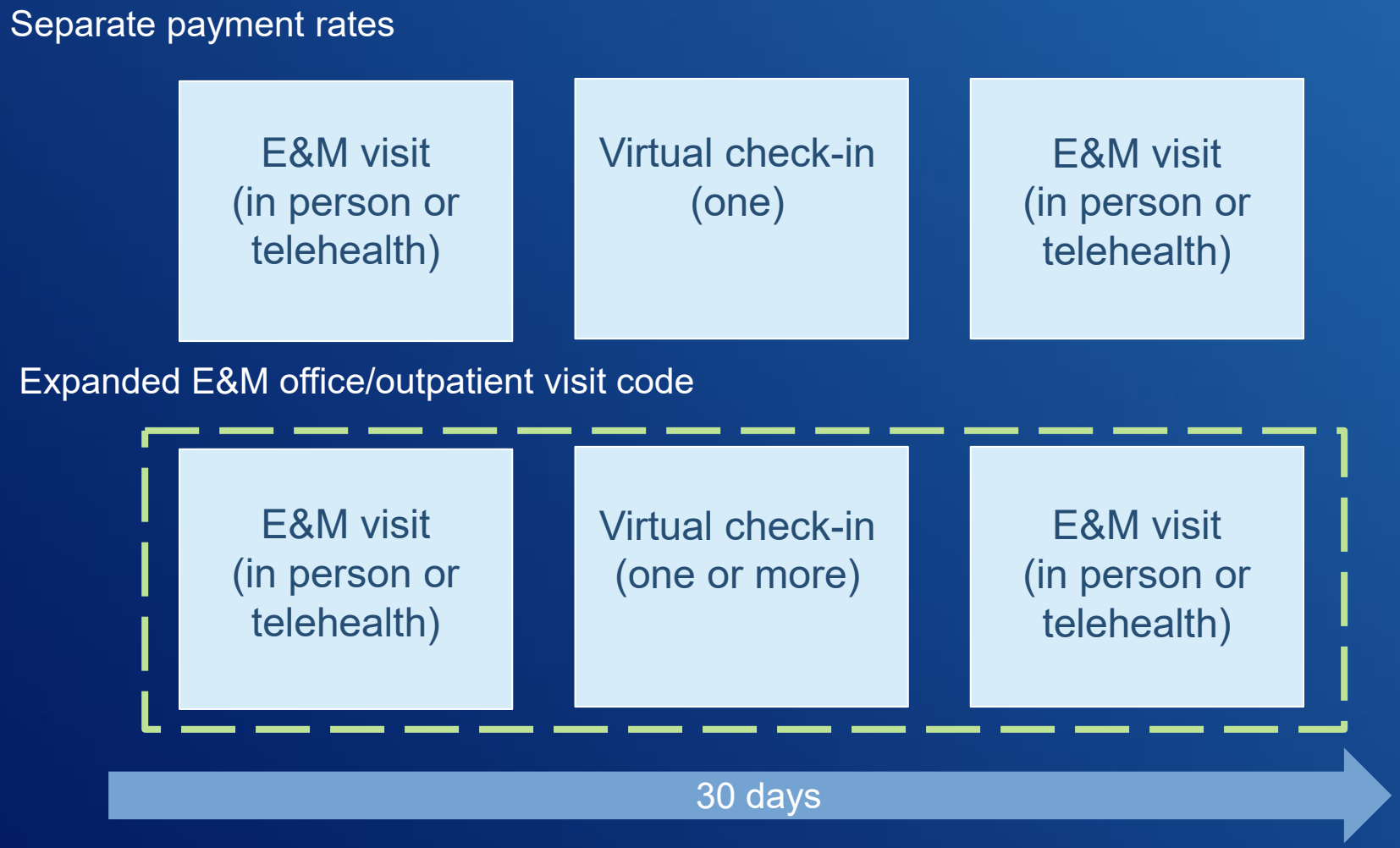
Note: E&M (evaluation and management).

Precedents for bundled payments in PFS

- Monthly payment that covers outpatient dialysis-related physician services for ESRD patients
- Global surgical policy: Payment covers the procedure and postoperative visits during global period (0,10, or 90 days)
  - Payment rate for each code assumes that clinician provides a certain number of postoperative visits
  - But there is evidence that clinicians actually provide fewer visits than are assumed in payment rates for 10-day and 90-day codes
  - Thus, many procedures appear to be overvalued
  - Demonstrates importance of monitoring changes in care delivery and adjusting payment rates to reflect changes

Note: PFS (physician fee schedule), ESRD (end-stage renal disease).

Illustration of expanded E&M office/outpatient visit code



Note: E&M (evaluation and management).

Creating expanded E&M office/outpatient visit codes: Design questions

- Which services to include in expanded E&M codes?
- What time period should the codes cover?
- How to account for variation in time and resources?
- How to determine payment rates?
- How to ensure that payment rates remain accurate over time?

Note: E&M (evaluation and management).

During PHE, Medicare temporarily expanded coverage of telehealth services provided by FQHCs and RHCs

Medicare generally pays higher rates for FQHC and RHC services than for PFS services

	Before the PHE	During the PHE
Which telehealth services are FQHCs and RHCs able to bill Medicare for?	Could only bill as the originating site; could not bill for services as the distant site.	Can bill for services as the distant site. Can provide services to beneficiaries in any location, including at home. Can bill for any service that is an allowable telehealth service under the PFS.
How does Medicare pay FQHCs and RHCs for telehealth services?	Medicare did not pay them for telehealth services (unless they served as an originating site).	Paid a rate based on PFS rates (less than their usual rate for in-person services).

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Note: PHE (public health emergency), FQHCs (federally qualified health centers), RHCs (rural health clinics), PFS (physician fee schedule).

Alternative approach to paying for FQHC and RHC telehealth services after the PHE

- Pay FQHCs and RHCs a rate that is based on PFS rates for telehealth services instead of their standard payment rates (about 50% less than standard rates)
  - Would reflect lower facility costs of providing telehealth
  - Would achieve payment parity for telehealth across settings
  - Would balance the dual goals of ensuring access to care and prudent fiscal stewardship of Medicare

Note: FQHCs (federally qualified health centers), RHCs (rural health clinics), PHE (public health emergency), PFS (physician fee schedule).

For Commission discussion

- Feedback on:
  - Plan for analyzing changes in telehealth volume and spending, and impact of telehealth on access and quality
  - Alternative approach to paying for telehealth services under the physician fee schedule
  - Alternative approach to paying for telehealth services billed by FQHCs and RHCs
- Other material you would like us to include in the report?
- Mandated report will be part of June 2023 report