Mandated report: Telehealth in Medicare

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Outline of presentation

- Mandated report on telehealth in Medicare
- Temporary expansions of telehealth during and after the PHE
- Commission's policy option for telehealth after the PHE
- Previous Commission discussions
  - Alternative approaches to paying for telehealth services
  - Telehealth utilization and spending
  - Future program integrity reviews and analysis
- Effects of telehealth expansions on quality, access, and cost during the COVID-19 pandemic

Note: PHE (public health emergency).

CAA, 2022: Telehealth report due June 2023

- Use of telehealth services (*January 2023*)
- Medicare expenditures on telehealth (*January 2023*)
- Medicare payment policy for telehealth services and alternative approaches under the PFS and the payment systems for FQHCs and RHCs (*September 2022*)
- The effects of expanded telehealth coverage on quality, access, and cost (*today*)

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).

Most telehealth flexibilities are temporarily extended after the PHE expires

	Before the PHE	During the PHE	After 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 in their homes.	Beneficiaries in rural and urban areas, including in their homes, through the end of 2024.
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.	CMS will temporarily pay for some telehealth services through the end of 2023, and certain services furnished through audio-only through 2024.
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).	PFS rate is the same as if the service were furnished in person (facility or nonfacility rate, depending on the clinician's location), through the end of 2023.

Note: PHE (public health emergency), PFS (physician fee schedule). Under the PFS, clinicians who provide services in facilities such as hospitals generally receive a lower payment rate (the facility rate) than clinicians who provide services in offices (the nonfacility rate). The PHE is expected to end May 11, 2023.

Temporary expansions are consistent with 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 select 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 any permanent changes to Medicare's telehealth policies

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

Alternative payment for telehealth

- Return to paying the lower PFS rate (i.e., the facility rate) for telehealth services
  - Services delivered via telehealth likely do not require the same practice costs as services provided in a physical office
  - Collect data on costs to provide telehealth services
- Pay rates comparable to PFS rates for telehealth services provided by FQHCs and RHCs
  - Would need legislative authority to be implemented
- Bundled payment policy for telehealth could be pursued, but implementation challenges exist

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

Telehealth use and spending in 2020 and 2021

- Telehealth use and spending peaked in the 2nd quarter of 2020 and leveled off by the end of 2021
- 40% of all Part B FFS beneficiaries received at least one telehealth service in 2020; 29% in 2021
- Annual FFS telehealth spending was $4.8 billion in 2020 and $4.1 billion in 2021
- E&M services accounted for almost all telehealth spending
- Spending for tele-behavioral health services grew in 2021

Note: E&M (evaluation and management).

Data are preliminary and subject to change.

Future program integrity reviews and analyses

- Secretary required to conduct a study of program integrity related to telehealth using medical records
- Our analysis supports the need to review the length of telehealth visits
  - Distribution of the levels of office/outpatient visits was about the same for in-person and telehealth
  - However, in focus groups, most clinicians said that telehealth visits take less time
- Starting in 2023, clinicians will be required to indicate on claims when telehealth is delivered via audio-only

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Note: The Consolidated Appropriations Act, 2023, requires the Secretary to conduct a study on program integrity related to telehealth services. An interim report is due by October 1, 2024, and final report is due by April 1, 2026.

Assessing the impact of telehealth on quality, access, and cost: Limitations

- Pre-pandemic literature and data are of limited use in understanding the impact of expanded telehealth
- Difficult to reliably measure the quality of clinician care
- Medicare lacks comprehensive data sources (e.g., lab results, patient-reported outcomes)
- Time period of available FFS claims data overlaps with surges in COVID-19 cases (2021)

Effects of expanded telehealth coverage on quality, access, and cost during the COVID-19 pandemic

Is greater use of telehealth associated with changes in quality, access, and costs?

- Aim: Assess the feasibility of using population-based measures to estimate the association between telehealth use and outcomes measures
- Used 2021 claims data, but need to gather more evidence before making permanent policy decisions

Note: FFS (fee-for-service).

Compare changes in population-based outcomes across HSAs with different levels of telehealth use

- Population-based measures
  - **Quality:** Risk-adjusted ACS hospitalizations and ACS ED visits per 1,000 beneficiaries
  - **Access:** Total clinician encounters per FFS Medicare beneficiary
  - **Cost:** Total cost of care (Parts A and B) per beneficiary
- Time periods
  - 2nd half of 2019 (before telehealth expansion)
  - 2nd half of 2021 (during telehealth expansion)
- Telehealth intensity: HSAs categorized based on the number of telehealth visits per 1,000 beneficiaries (low and high)

Note: FFS (fee for service), HSA (hospital service area), ACS (ambulatory care sensitive), ED (emergency department). HSAs are defined by the Dartmouth Atlas of Health Care to represent health care markets. Low and high denote telehealth intensity in the second half of 2021.

Difference-in-differences (DID) framework

- Comparing outcomes before and after telehealth expansion does not account for other influences
- Applied DID to measure the association between interventions and outcomes
  - Difference in outcome in the high telehealth-intensity HSAs across two time periods minus the difference in outcome in the low telehealth-intensity HSAs across the same time periods
- Also added controls for factors that could confound the association between telehealth and outcomes

Note: HSA (hospital service area).

Risk-adjusted ACS hospitalization rates across low and high telehealth-intensity HSAs

	Before telehealth expansion (2nd half of 2019)	During telehealth expansion (2nd half of 2021)	Difference	DID (no controls)	DID (with controls)
Low telehealth-intensity HSAs	25.40	17.89	- 7.51	1.39***	1.63***
High telehealth-intensity HSAs	23.54	17.42	- 6.12		

Note: (ACS) ambulatory care sensitive, (HSA) hospital services area, (DID) difference-in-differences. We calculated the risk-adjusted rates of hospitalizations tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries in each HSA. High intensity-HSAs had rates of telehealth use in the second half of 2021 that were in the top third of the distribution; low intensity-HSAs had rates in the bottom third. "***" denotes statistical significance at 1 percent.

Source: Analysis of fee-for-service Medicare claims data.

Risk-adjusted ACS ED rates across low and high telehealth-intensity HSAs

	Before telehealth expansion (2nd half of 2019)	During telehealth expansion (2nd half of 2021)	Difference	DID (no controls)	DID (with controls)
Low telehealth-intensity HSAs	46.22	37.73	- 8.49	0.18	0.10
High telehealth-intensity HSAs	36.05	27.74	- 8.31		

Note: (ACS) ambulatory care sensitive, (ED) emergency department, (HSA) hospital services area, (DID) difference-in-differences. We calculated the risk-adjusted rates of ED visits tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries in each HSA. High intensity- HSAs had rates of telehealth use in the second half of 2021 that were in the top third of the distribution; low intensity-HSAs had rates in the bottom third. Neither of the DID impact estimates are statistically significant.

Source: Analysis of fee-for-service Medicare claims data.

Risk-adjusted ACS hospitalizations and ED use DID findings

- Risk-adjusted rates of ACS hospitalizations decreased in both groups of HSAs, but decreased at a slower rate among high telehealth-intensity HSAs
- No association between telehealth intensity and risk-adjusted ACS ED visit rates
- HSAs with high telehealth intensity do not appear to be associated with improved rates of ACS hospitalizations or ED visits relative to HSAs with low telehealth intensity

Note: HSA (hospital service area), ACS (ambulatory care sensitive), ED (emergency department).

Total clinician encounters per beneficiary across low and high telehealth-intensity HSAs

	Before telehealth expansion (2nd half of 2019)	During telehealth expansion (2nd half of 2021)	Difference	DID (no controls)	DID (with controls)
Low telehealth-intensity HSAs	8.64	8.39	- 0.25	0.10***	0.30***
High telehealth-intensity HSAs	11.28	11.12	- 0.16		

Note:, (HSA) hospital services area, (DID) difference-in-differences. We define "encounters" as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the physician fee schedule service. High intensity- HSAs had rates of telehealth use in the second half of 2021 that were in the top third of the distribution; low intensity-HSAs had rates in the bottom third. "***" denotes statistical significance at 1 percent.
Source: Analysis of fee-for-service Medicare claims data.

Data are preliminary and subject to change.

Total clinician encounters per beneficiary DID findings

- Total clinician encounters decreased in both groups of HSAs, but decreased at a slower rate among high telehealth-intensity HSAs
- HSAs with high telehealth intensity appear to be associated with increased rates of total clinician encounters relative to HSAs with low telehealth intensity
  - Could be due to convenience, not having to leave home if feeling ill, and decrease in "no show" rates

Note: HSA (hospital service area).

Data are preliminary and subject to change.

Total cost of care per beneficiary across low and high telehealth-intensity HSAs

	Before telehealth expansion (2nd half of 2019)	During telehealth expansion (2nd half of 2021)	Difference	DID (no controls)	DID (with controls)
Low telehealth-intensity HSAs	$6,138	$6,367	$229	$30	$165***
High telehealth-intensity HSAs	$6,672	$6,930	$258		

Note: (HSA) hospital services area, (DID) difference-in-differences. Total cost of care for Part A and Part B services per FFS Medicare beneficiary, which includes Medicare payments, beneficiary cost-sharing, and primary payer payments. High intensity- HSAs had rates of telehealth use in the second half of 2021 that were in the top third of the distribution; low intensity-HSAs had rates in the bottom third. "***" denotes statistical significance at 1 percent.
Source: Analysis of fee-for-service Medicare claims data.

Data are preliminary and subject to change.

Total cost of care per beneficiary DID findings

- Total cost of care per beneficiary increased across all HSAs, but increased more in high telehealth-intensity HSAs
- HSAs with high telehealth intensity do not appear to be associated with lower total cost of care relative to HSAs with low telehealth intensity
  - Partially due to additional spending on clinician encounters and hospitalizations

Note: HSA (hospital service area), ACS (ambulatory care sensitive).

Data are preliminary and subject to change.

Summary

- We have confidence in this approach to assess the association between telehealth and population-based outcomes
- Underlying data confounded by COVID-19, so we can not make causal interpretations of our findings; however they:
  - Support the hypothesis that telehealth likely improved access to care for some beneficiaries
  - Do not support the hypothesis that telehealth improved quality outcomes or lowered costs
- Consistent with the Commission's policy option, more evidence is needed before making permanent decisions

Conclusion

- Mandated report will be part of the June 2023 report to the Congress
- Comments on materials?