*Advising the Congress on Medicare issues*

# Mandated report on telehealth: Updates on telehealth use and beneficiary and clinician experiences

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# Outline of presentation

- Mandated telehealth report
- Temporary expansions of telehealth during the PHE
- Commission's policy option for telehealth after PHE
- Medicare's changes to telehealth policy since the PHE
- Update on telehealth spending and use
- Beneficiary and clinician experiences with telehealth
- Telehealth and program integrity



Note: PHE (public health emergency).

# CAA, 2022: Telehealth report due June 2023

- Use of telehealth services (*today*)
- Medicare expenditures on telehealth (*today*)
- Medicare payment policy for telehealth services and alternative approaches under the PFS and the payment systems for FQHCs and RHCs (*late September 2022*)
- The impact of expanded telehealth coverage on access to care and quality (*April 2023*)

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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 in their 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

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: PHE (public health emergency), 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 telehealth flexibilities until December 31, 2024
- 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
- Required claims modifier for audio-only services, consistent with Commission recommendation (March 2022)



Note: PHE (public health emergency).

# FFS Medicare spending for telehealth services peaked in the 2nd quarter of 2020

- Annual FFS telehealth spending: $4.8 billion in 2020, $4.1 billion in 2021
- 87% of telehealth spending was for clinician services paid under PFS
- 13% was for other providers (e.g., federally qualified health centers, rural health clinics)

Note: FFS (fee for service), PFS (physician fee schedule)
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.

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Data are preliminary and subject to change.

# Number of FFS Medicare beneficiaries who received a telehealth service peaked in the 2nd quarter of 2020

Note: FFS (fee for service).
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.

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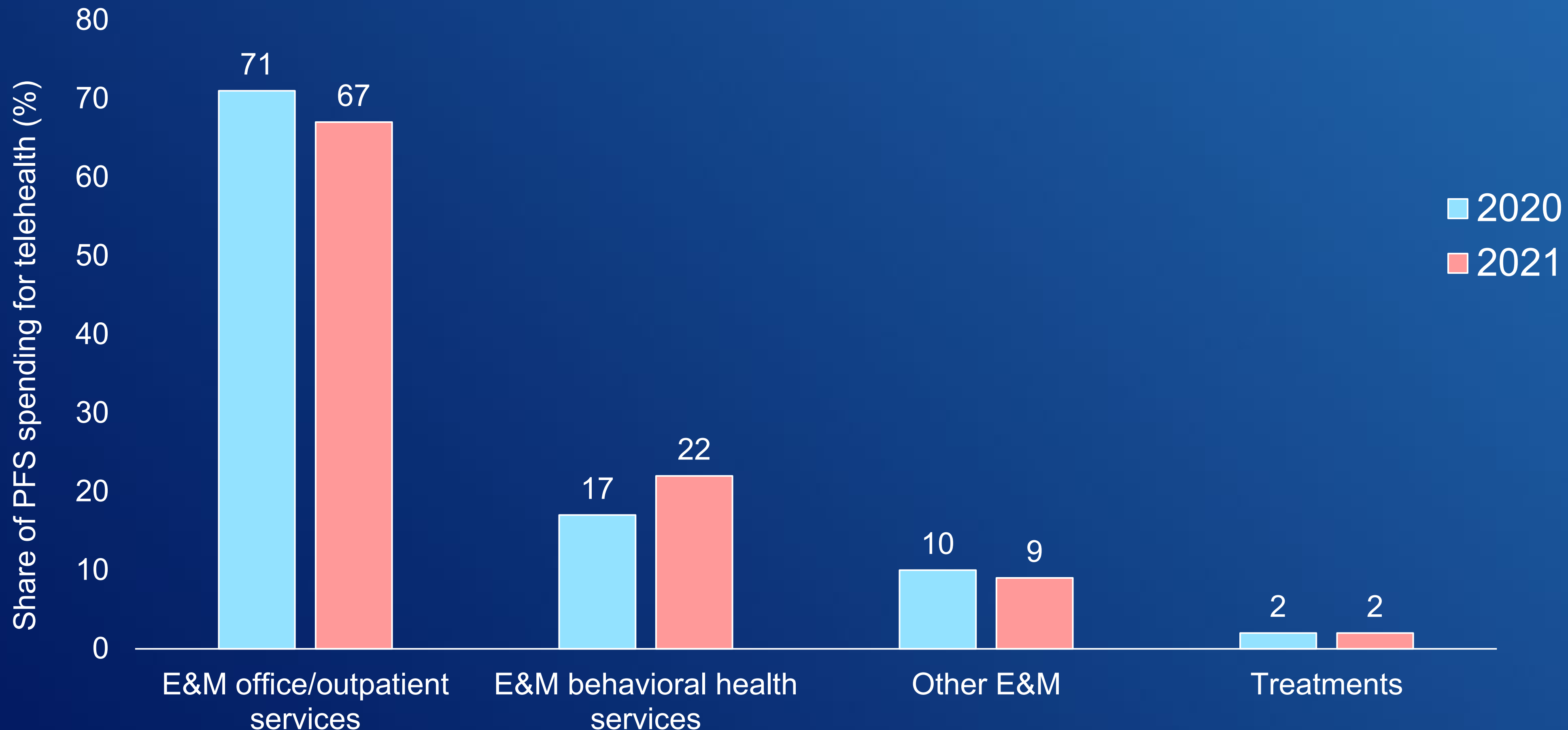
Data are preliminary and subject to change.

# E&M office/outpatient visits accounted for majority of telehealth spending in 2020 and 2021

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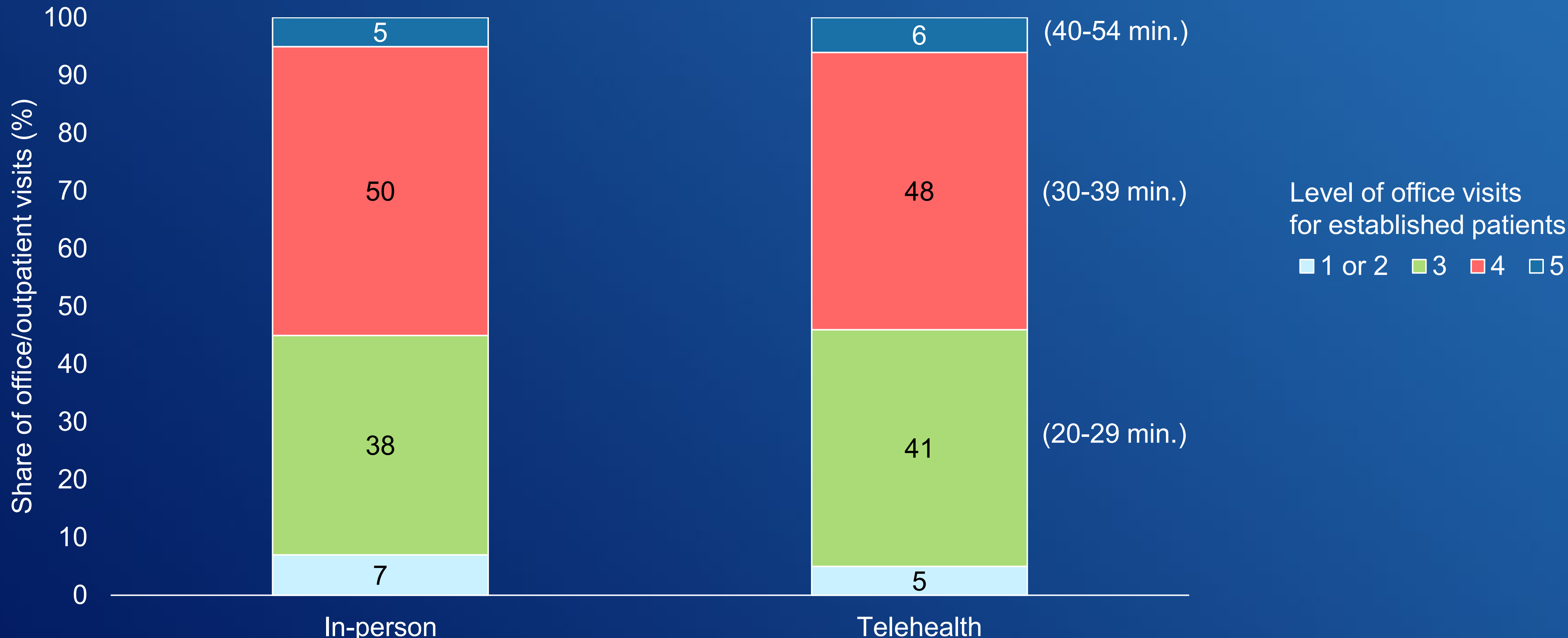
Note: E&M (evaluation and management), PFS (physician fee schedule).
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.

Data are preliminary and subject to change.

# Distribution of E&M office/outpatient visit codes for established patients was similar for in-person and telehealth services, 2021




Note: E&M (evaluation and management), FFS (fee for service). Levels of office/outpatient visits for established patients represent Current Procedural Terminology codes 99211-99215. Numbers may not sum to 100% due to rounding.
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.



Data are preliminary and subject to change.

# Use of telehealth services varied by type of clinician, 2021

| Clinician type | Number of clinicians providing telehealth | Share of all clinicians providing telehealth | Telehealth spending per clinician |
|---|---|---|---|
| **Specialist physicians** | 201,500 | 37% | $7,200 |
| **APRNs and PAs** | 131,500 | 24 | 4,000 |
| **Primary care physicians** | 120,800 | 22 | 7,600 |
| **Licensed clinical social workers** | 41,200 | 8 | 8,200 |
| **Clinical psychologists** | 22,500 | 4 | 14,700 |
| **Other practitioners** | 21,100 | 4 | 1,700 |
| **Total** | 538,600 | 100 | 6,700 |

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care physicians" include family medicine, internal medicine, pediatric medicine, and geriatric medicine. "Other practitioners" include clinicians such as physical therapists and podiatrists. Table counts telehealth services provided to Medicare fee-for-service (FFS) beneficiaries and billed under the physician fee schedule. Spending includes Medicare program spending and beneficiary cost sharing.
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.

Data are preliminary and subject to change.

# Small share of telehealth services were provided to beneficiaries in a different state than the clinician

- During PHE, all states created temporary waivers to allow clinicians to provide telehealth services to out-of-state patients
- In FFS Medicare, small share of telehealth services were provided to beneficiaries in a different state than the clinician
  - 5.1% in 2020, 6.0% in 2021
- Share of telehealth services provided to out-of-state beneficiaries varied by type of service
  - 21.5% of E&M visits to patients in ED, 4.7% of care management/care coordination services
- Share of telehealth services provided to out-of-state beneficiaries varied by state

Note: PHE (public health emergency), FFS (fee for service), E&M (evaluation and management), ED (emergency department).
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.



Data are preliminary and subject to change.

# Other findings from analysis of FFS Medicare claims for telehealth services

- Mental, behavioral, and neurodevelopmental disorders accounted for 34% of spending for telehealth in 2021 (up from 25% in 2020)
- Number of telehealth services per FFS beneficiary varied by geographic region, but changes in use of telehealth in 2020 and 2021 were similar across regions
- Certain groups of FFS beneficiaries received more telehealth services per beneficiary than others in 2021: Under age 65, disabled, had end-stage renal disease, had lower incomes, lived in urban areas

Note: FFS (fee for service).
Source: Analysis of Medicare claims data for 100 percent of FFS beneficiaries.



Data are preliminary and subject to change.

# Beneficiary and clinician experiences with telehealth from focus groups (Summer of 2022)

- Beneficiaries reported telehealth visits mainly with clinicians with whom they have a relationship
- Beneficiaries were generally satisfied with telehealth visits
- Many clinicians reported that they continue to provide telehealth
  - Some clinicians appreciated the convenience, flexibility, and improved access for patients
  - Others preferred in-person visits due to perceived better quality of care or to provide procedures and testing

# Beneficiary and clinician experiences with telehealth from our focus groups (cont.)

- Clinicians reported that telehealth visits generally take less time than in-person visits
- Most clinicians believed telehealth costs less than in-person visits
- Many beneficiaries and clinicians would like to continue the option of telehealth visits

# Telehealth and program integrity

- Policymakers have been cautious about covering telehealth services because
  - Little is known about the effect of telehealth on quality of care and patient outcomes
  - Telehealth may be more susceptible to overuse and fraud
- However, telehealth offers benefits to patients, including convenience and not having to leave home if feeling ill
- Key issue is how to achieve the benefits of telehealth while limiting the risks to beneficiaries and the program

# HHS OIG review of telehealth services to date

- Reviewed FFS Medicare telehealth claims using several program integrity measures with high thresholds
  - Identified 1,700 high-risk providers (0.2% of all telehealth providers) who received $128 million in payments
- Recommended that CMS take actions to improve program integrity including:
  - Strengthening monitoring and targeted oversight of telehealth services
  - Improving the transparency of “incident to” services when clinical staff primarily deliver a telehealth service



Note: HHS (Health & Human Services), (OIG) Office of Inspector General), FFS (fee for service). Review included Medicare claims from March 2020 through February 2021.

# 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 duration of telehealth services
  - Distribution of the levels of office/outpatient visits was about the same for in-person and telehealth visits
  - In focus groups, most clinicians said that telehealth visits take less time
- Starting in 2023, clinicians will be required to indicate on claims when they provide audio-only telehealth services

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.

# Conclusion

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