Mandated report: Telehealth services and the Medicare program

Amy Phillips, Zach Gaumer, and Andy Johnson

January 12, 2018

MEDPAC

Presentation outline

- Mandate
- Background
- Medicare coverage and use of telehealth services
- Commercial insurance coverage of telehealth services
- Principles for evaluating coverage expansions
- Discussion

MedPAC report mandated by Congress in the 21st Century Cures Act of 2016

By March 15, 2018, MedPAC shall provide information to the committees of jurisdiction that identifies:

1. The telehealth services for which payment can be made, under the fee-for-service program under Medicare Parts A and B; (September)

2. The telehealth services for which payment can be made under private health insurance plans; (October)

3. Ways in which telehealth services covered under private insurance plans might be incorporated into the Medicare fee-for-service program (including any recommendations for ways to accomplish this incorporation). (November)

Definition and background

- Three modalities of telehealth:
  - Direct-to-consumer (DTC): Patient initiated telephone or two-way video virtual visits with clinicians from any location
  - Provider-to-provider (PTP): A clinician at an originating site – in the presence of a patient – initiating communication with a clinical specialist at a distant site
  - Remote patient monitoring (RPM): A patient at home or at a facility being monitored by a clinician from a remote location using two-way video or other electronic device
- June 2016 MedPAC chapter: Mixed findings
- Medicaid, DOD, VA cover telehealth to varying degrees
- 35 states have telehealth parity laws

Telehealth utilization

- Most common services across all payers: E&M office visits and tele-mental health visits
- Telehealth use low in 2016 across all payers
  - Medicare: 0.3 percent of Part B beneficiaries
  - Other payers: ~1 percent of patients
- Rapid growth in Medicare (2014-16): 79 percent increase
- Advocates: Telehealth expands access and convenience, improves quality, and reduces costs
- Critics: A supplemental service that may increase costs
- Medicare data suggest telehealth E&M services supplement—not substitute for—other services
  - Telehealth users: 6.6 non-telehealth claims and 1.6 telehealth claims
  - Non-telehealth users: 6.6 non-telehealth claims

Mandate issue #1: Medicare coverage of telehealth

1. Risk-bearing entities—MA plans/ACOs: Flexible
2. Fee-for-service (FFS) payment systems other than the Physician fee schedule (PFS): Flexible
3. PFS: Constrained

Risk-bearing entities—MA plans/ACOs: Flexible

- Medicare Advantage plans
  - Coverage parameters: Must mirror telehealth coverage under FFS
  - Payment: Capitated payments for services covered under FFS
  - Flexibility to cover additional telehealth through supplemental premiums and rebate dollars
  - Incentive: Use telehealth if it reduces costs (at risk if beneficiary costs exceed payment)
- ACOs (two-sided):
  - Coverage parameters: Given a waiver from PFS rules to cover telehealth in urban areas and in the patient's residence
  - Payment: Paid FFS rates, but bonus payments or losses tied to cost savings and quality
  - Incentive: Use telehealth if it reduces costs (risk of not receiving bonus payment if annual beneficiary costs exceed target)

Fee-for-service payment systems other than Physician fee schedule: Flexible

- Telehealth services are contemplated within the fixed payment for patient encounters:
  - Inpatient hospital, outpatient hospital, skilled nursing facilities, long-term care hospitals, inpatient rehabilitation, dialysis facilities, home health, and hospice
- Incentive: Use telehealth if it reduces costs (at risk if cost of encounter exceeds fixed payment)

Physician fee schedule (PFS): Constrained

- Coverage: Restricts locations, geographies (rural), modalities, and services covered
- Payment: Each discrete service paid separately
  - Cost sharing: 20% (of originating site and distant site fee)
  - Medigap often shields beneficiaries from cost sharing
- Incentive: Increase volume of services
- Exception: Several PFS management codes

Mandate issue 2: Commercial insurance plan coverage of telehealth

- Most plans covered some telehealth, few comprehensively
- Coverage varied widely, but many plans cover basic physician and mental health visits
- Urban originating sites widely permitted
- Cost-sharing varied by plan and services type
- Pilot programs commonly used to test implementation
- Rationale: Employer demand and competition with other insurers, not cost reduction
- Outcomes: Low use, expanded access and convenience, little evidence of cost savings

Mandate issue 3: Incorporating commercial plan telehealth coverage into Medicare

- Plans do not offer a clear, homogenous model
- Plans consider cost a secondary motivation for making telehealth coverage decisions; cost is critical to Medicare
- Plans have tools to control volume incentives; under the PFS taxpayers not indemnified against volume incentive
- Plan cost-sharing varied; under PFS Medigap policies shield beneficiaries from cost-sharing
- Plans test telehealth prior to implementation; Medicare tests to a lesser degree
- Policymakers should use caution in further incorporating telehealth coverage into the PFS

Principles for evaluating telehealth services under Medicare

To be incorporated into Medicare, a telehealth service should strike a balance between the three principles:

1. Cost – Reduce costs for beneficiaries or the program
2. Access – Expand the availability of services or providers, facilitating a more timely delivery of care and increasing convenience
3. Quality – Improve outcomes and patient experience

Illustrative examples: Evaluating telehealth services used by commercial plans

Evaluation of principles may yield three categories of services:

1) Evidence of balanced principles is clear = consider incorporating
2) Evidence of balanced principles is less clear = use best judgement and consider utilization tools
3) Evidence of balanced principles is unclear = test through CMMI

Illustrative example #1: Telestroke

- Background: Medicare PFS covers telestroke in rural areas
- Policy option: Expand to urban originating sites
- Costs:
  - Increase due to more consults
  - Mitigated by lower risk of misuse and potential for long-term savings from reducing disabilities
- Access: May enable more timely access to neurologists
- Quality: Expanded access has generated better outcomes
- Determination: Clear evidence of balanced principles

Illustrative example #2: Tele-mental health services

- Background: Medicare PFS covers tele-mental health in rural areas
- Policy options: Expand to urban originating sites or the patient residence
- Costs:
  - Increased costs due to large pool of users
  - Potential for misuse similar to E&M visits
  - Costs higher for expansion to patient residence
- Access: Expand access to clinicians in limited supply, increase convenience, encourage patients to seek care
- Quality: Potential for improvement but evidence limited
- Determination: Less clear evidence of balanced principles

Illustrative example #3: Direct-to-consumer (DTC) services

- Background: Not covered by the Medicare PFS
- Policy option: Cover DTC services in urban and rural areas
- Costs:
  - Increased costs due to large pool of users and routine services
  - Potential for misuse high because patient-initiated from any location
  - Medigap policies shield beneficiaries from cost-sharing
- Access: Potential to expand access to clinicians and increase convenience
- Quality: Potential to improve quality, but evidence unclear
- Determination: Unclear evidence of balanced principles

Summary

- Medicare covers telehealth in several settings:
  - Flexible in MA plans, two-sided ACOs, and other FFS systems
  - PFS limited to rural areas
- Commercial plan coverage of telehealth varies widely; motivated by employer demand and competition
- Commercial plans not a clear and consistent model
- Principles (cost, access, quality) should be used to evaluate the incorporation of telehealth services
- Policymakers should evaluate services individually; incorporate when balance of evidence is clear, test when unclear

Discussion

- Questions and final feedback
- Vote to forward the telehealth report to Congress