# EXPANSION OF TELEHEALTH IN MEDICARE

## EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission (MedPAC) convened a session to examine the expansion of telehealth in Medicare during the COVID-19 public health emergency (PHE) and how to make some of the flexibilities permanent. MedPAC staff presented policy option in which providers who participate in advanced alternative payment models (A-APMs) are permitted to continue the telehealth flexibilities, while fee-for-services (FFS) providers revert to pre-public health emergency telehealth rules or limited expansions. The Commissioners were generally supportive of allowing A-APMs clinicians full access to the telehealth flexibilities, while permitting a limited telehealth expansion for FFS provider in areas that would most benefit, such as mental health and primary care. Other Commissioners were concerned that this expansion of telehealth would result in dramatic increases in costs and suggested that the expansion be strategically rolled out to examine the impact on health outcomes and costs.

## STAFF PRESENTATION

**Senior Analyst Ledia Tabor** began the presentation by detailing how the Centers for Medicare and Medicaid Services (CMS) expanded access to telehealth during the PHE by permitting access to services outside of rural areas and originating sites and adding over 80 additional services, including audio-only evaluation and management (E&M) visits. She further detailed that these services during the PHE were reimbursed at the same rate as if there were furnished in-person, with the ability for providers to reduce or waive cost sharing, and penalties were not imposed for using non-HIPPA compliant technologies.

**Principal Policy Analyst Ariel Winter** then detailed the desire from advocates to continue the telehealth expansion after the PHE ends. To address this inevitability, Mr. Winter outlined a policy option in which telehealth expansions would continue for clinicians participating in A-APMs that assume financial risk for total Medicare spending and quality of care. He noted that this option would have less concern that expanded coverage of telehealth will lead to higher spending and could encourage clinicians to participate in A-APMs. As for FFS clinicians, the Commission is concerned that telehealth expansion could increase volume and spending, but if some expansions are permitted safeguards would need to be implemented.

Under this proposed policy, Mr. Winter detailed that clinicians in A-APMs could continued to provide telehealth services to patients in non-rural areas and the patients could receive services within their home. The Commission suggested that most expanded telehealth services remain in place, for the exception of audio-only services because of the possibility for audio-only to illicit additional services. Additionally, Mr. Winter noted that reimbursement rates for telehealth services would revert to the lower pre-PHE level and technology would need to be HIPPA compliant.

For FFS clinicians, the Commission recommended that if some expansions were made permanent, safeguards would be needed. Possible expansions for FFS could include telehealth for mental health services or primary care. Mr. Winter detailed that potential safeguards could include requiring a face-to-face visit to order durable medical equipment (DME) or lab tests that have been a source of fraud and waste in the past.

## COMMISSIONER DISCUSSION

**Commissioner Karen DeSalvo** began commissioner discussion by emphasizing how the COVID-19 pandemic has forced the healthcare industry to come into the 21st century and realize the benefits of technology, such as telehealth. She detailed that the Commission must now face how to move forward with telehealth and deicide which services provide the greatest benefit to beneficiaries while controlling costs. Commissioner DeSalvo expressed support for the A-APM policy option and the opportunity for these providers to look upstream and control costs through flexible telehealth utilization. Regarding payment, she stated that telehealth parity does not need to exist, but technology should be HIPPA compliant to protect privacy. Commissioner DeSalvo was concerned about the digital divide and the difficulties older individuals face in accessing telehealth technology, and suggested that the Commission examine this issue in the future.

**Commissioner Wayne Riley** recounted first-hand experiences with telehealth during the PHE and how it expanded access for chronic disease management and primary care during the PHE. He was also supportive of audio-only services to help address chronic disease management. He noted that it will be important for the Commission to consider the balance between access to services and the costs associated with increased access. To this point, Commissioner Riley was supportive of guardrails to prevent fraud, waste, and abuse.

**Commissioner Sue Thompson** was incredibly supportive of expanding telehealth beyond the PHE because of its ability to increase access for many Medicare beneficiaries. She urged the Commission to think of telehealth as a tool for access, instead of a service that increases volume, and the Commission should not support policies that limit access. To guard against increased utilization, and therefore increased costs, Commissioner Thompson suggested that the existing oversight efforts be applied to monitor and revise telehealth policies as necessary.

**Commissioner Betty Rambur** agreed with the staff that full risk bearing providers should have the flexibility to use all tools available, including telehealth and audio-only, to control costs. She was also supportive of telehealth services for chronic disease management. Commissioner Rambur also suggested that FFS providers be provided the flexibility to furnish telehealth services for high-risk and low mobility beneficiaries, and recommended that the Commission examine potentially differential policies for special populations.

**Vice Chair Paul Ginsburg** was also supportive of the A-APM distinction and how it provides incentives for clinicians to move towards A-APMs. In order to avoid fraud and abuse, Commissioner Ginsburg recommended that cost-sharing for patients be incorporated because fraud is less likely to occur when the patient shares financial responsibility. He also suggested examining Medicare Advantage and how their flexibilities will align with the new flexibilities.

**Commissioner Dana Gelb Safran** was supportive of the movement to increased telehealth access, but expressed concern about how the expansion would affect the Medicare budget and budget growth. She emphasized the importance of studying the expansion as it is rolled out and examining the impact on access, outcomes, and costs.

**Commissioner Marjorie Ginsburg** was one of the few commissioners to express pause about the expansion. She stated that this proposal raises "red flags" for its potential to dramatically increase the precarious Medicare budget. She suggested systematically rolling out the expansion to select A-APMs and monitoring its progress for two to three years before more broadly expanding. **Commissioner Jaewon Ryu** also supported testing the expansion in A-APMs.

**Commissioner David Grabowski** supported expanding telehealth in A-APMs, but expressed concern about excessive use and low value for FFS providers. He suggested that the Commission consider whether telehealth services be covered for all high-risk patients where access is difficult and other populations where the telehealth value will be most realized. He recommended that this could be achieved by expanding telehealth by provider type, such as primary care, or by condition like stroke, substance-use disorder, and diabetes.

**Commissioner Jonathan Jaffery** and **Commissioner Larry Casalino** also expressed considerable support for preserving audio-only telehealth services after the PHE.

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