EXPANSION OF TELEHEALTH IN MEDICARE

EXECUTIVE SUMMARY

The Medicare Payment Advisory Commission (MedPAC) convened a session further discussing the Commission's views on expanding access to telehealth in Medicare following the COVID-19 pandemic. MedPAC staff outlined a series of policy options for the Commissioners to consider as they begin work to finalize a set of recommendations to Congress. Overall, Commissioners appeared largely in favor of broadly expanding access to telehealth, though many prefaced this support with the recognition that more data was needed before making certain definitive decisions. Despite this, however, Commissioners generally aligned around the following contentions:

- Telehealth should be reimbursed at a lower rate than in-person services;
- Some services should not be coverable via telehealth and should remain face-to-face services;
- Some reform is required for "incident to" billing requirements;
- Telehealth should include some degree of cost-sharing;
- Access to audio-only services should be preserved; and
- Certain guardrails will be required to prevent overuse of telehealth services (e.g., a cap on how many telehealth services a provider can furnish in a given time period).

STAFF PRESENTATION

MedPAC Senior Analysts Ariel Winter and Ledia Tabor presented on the rapid expansion of telehealth under Medicare during the COVID-19 pandemic and the available policy options for telehealth post-pandemic. Staff noted first that the telehealth environment has flourished since the beginning of the pandemic, and that advocates of the care modality assert that broad access to it should be maintained once the pandemic concludes. On the other hand, they stated others are concerned that broad use of telehealth would increase utilization and Medicare spend under fee-for-service system; that there is a high potential for fraud; and that the existing evidence is mixed on telehealth's impacts on quality of care.

Staff then outlined a series of long-term policy options for telehealth, which follow below:

- Medicare coverage of certain telehealth services to all beneficiaries and available in beneficiaries' homes;
- Coverage of many, but not all, of the telehealth services covered under the PHE (limited to services for which access is currently limited and for services that either improve or do not reduce quality of care);
- Eliminate temporary coverage of audio-only services once the public health emergency ends;

- Pay lower Medicare rates for telehealth services than for in-person services;
- Require HIPAA compliance for telehealth technology;
- Require cost sharing for telehealth services;
- Establish safeguards to protect the Medicare program and beneficiaries from unnecessary spending and potential fraud, including:
    - Studying whether to set frequency limits for certain telehealth services;
    - Requiring clinicians to provide a face-to-face visit before they order high-cost DME and clinical lab tests;
    - Prohibiting "incident to" billing for telehealth services provided by clinicians who can billy Medicare directly, such that any clinician who can bill Medicare on their own must do so; and
    - Prohibiting "incident to" billing for telehealth services if clinicians provide direct supervision remotely.

CLARIFYING QUESTIONS

MedPAC Vice Chairman Paul Ginsburg, PhD of the Brookings Institution asked whether it may be more prudent to wait until there is more data available to make long-term policy decisions around telehealth, but also recognized that there may be certain policy options that are "so obvious we want to do" that MedPAC may consider recommending they be done now. **MedPAC Executive Director James E. Mathews, PhD** responded that the "tension here is that we are indeed in the middle of the public health emergency" and that both Congress and CMS are under considerable pressure to legislate on telehealth now. He said that it "might be helpful for a group like us to start to say" which policy options are reasonable to pursue. **Bruce Pyenson, FSA, MAAA of Milliman, Inc.** similarly asked if it might make sense to recommend policies on a time-limited basis, with the recognition that technology is evolving rapidly and that telehealth may look very different in just a few years. Staff noted this is something they could consider.

Pat Wang, JD of Healthfirst asked whether there was any evidence of audio-only services positively impacting behavioral health. Staff noted they did not specifically ask for this information during the focus groups they conducted but will research the topic further.

COMMISSIONER DISCUSSION

Jonathan Perlin, MD, Phd, MHSA of HCA Healthcare called telehealth the "genie that isn't going back in the bottle" and that he substantially agrees with the recommendations for expanding its use under Medicare. Specifically, he suggested there should be more deliberation before deciding whether to eliminate coverage of audio-only services after the PHE, stating that such services confer an important benefit to those living in rural areas where broadband is limited, and to individuals with limited access to more sophisticated technology. He also suggested that there may be less of a need for HIPAA concerns around allowing individuals to seek care via unsecured technologies, especially for individuals who are "proficient with FaceTime" and other similar applications. **Brian DeBusk, PhD of DeRoyal Industries** agreed on this point and added that emphasis should move away from securing point-to-point conversations, saying instead that the greatest security threats involve large scale data breaches.

Brian DeBusk: Hope we do revisit the idea of ending audio only visits. I do see merit in this. Access issues are important – access to broadband/certain technologies. Other thing I want to point out is audio telephone calls are still the most secure form of communication. I think our emphasis should shift away from securing point to point conversations. It's toward larger scale data breaches and theft of other/ancillary person information. Pulling audio only and HIPAA into one issue. Phishing issues with clicking on links.

Lawrence Casalino, MD, PhD of the Weill Cornell Department of Healthcare Policy and Research stated he agreed with almost all of the policy recommendations, though noted he had concerns around the policy option regarding HIPAA. He also expressed concern around the cost sharing issue, agreeing that there "has to be some" but that imposing cost sharing could increase administrative burden on practices. He added that he is fervently against eliminating coverage for audio-only services, and that he supports continued coverage of such services for both equity and efficiency reasons. Last, he added commentary around the policy option to impose some form of frequency limits on accessing telehealth. He stated that doing so would be helpful, but that he believes tethering the limit to how many services a beneficiary could access would be administratively burdensome. He recommended instead setting the cap according to the number of services a provider could furnish, stating that tracking this would be simpler.

Paul Ginsburg supported the recommendation to pay less for telehealth services than in-person, as the marginal cost to providers for furnishing telehealth services in the long-run would be lower than in-person services. He added as well that paying for telehealth makes the most sense in a non-FFS environment, and that increased focus on telehealth reimbursement may further push Medicare away from the FFS system. **Pat Wang** expressed a similar view, stating that the discussion at hand hinges on the fact that the FFS system "limits innovation," and that it is because of the FFS system that the Commission is focusing so much attention on establishing safeguards against low-value care and fraud, waste, and abuse. She briefly suggested thinking through a potential "telehealth bundle" payment to be afforded to primary care physicians, who would have the flexibility to furnish the benefit as they deem fit. In addition, and in contrast to many other Commissioners, she "struggle[d]" with affording beneficiaries broad coverage of audio-only services, as they present a "trap door to a lot of abuse."

David Grabowski, PhD of Harvard Medical School agreed generally with the impetus to expand telehealth coverage but urged that guardrails should be put in place to prevent increased utilization of low-value care. He favored the option to cover many but not all telehealth services post-pandemic, and added that it will be important to identify what telehealth services are low-value and which ones should therefore not be afforded coverage following the PHE. He stated that the current lack of data on "what works and what doesn't" will be an impediment to determining which services should be considered low-value. In addition to these concerns, Dr. Grabowski also agreed that Medicare should pay for telehealth services at a lower rate than in-person care and that telehealth parity laws should be avoided. Last, he agreed that telehealth services should be subject to some degree of cost sharing.

Like many others, **Dana Safran, ScD of Haven Healthcare** questioned the recommendation around limiting coverage of audio-only services. She also emphasized the widely held belief that there is not enough data presently available to make determinations about telehealth's effects on quality, and that data should ultimately drive policymaking around telehealth. Last, she agreed with the sentiment around

telehealth's potential inflationary effect on Medicare spending and urged the Commission to "be eyes wide open" about this risk.

Jaewon Ryu, MD, JD of Geisinger Health System stated that he liked the balance struck by the policy options presented between the benefits of telehealth and the potential unintended consequences. For rural beneficiaries and those in APMs, he agreed there should be "even greater" flexibilities afforded to those populations. Like the balance struck by the policy options here. Balance between benefits of this modality care and potential for unintended consequences. He also suggested conceptualizing a distinction between chronic disease management and episode-based care as a way to think through certain telehealth guardrails. More specifically, he proffered that because chronic disease management generally depends more on consistent provider engagement as compared to services received in episodic care, the use of telehealth services for those receiving chronic care management should require a prior established relationship with the provider. **Betty Rambur, PhD, RN, FAAN of the Univeristy of Rhode Island** said this distinction was interesting and helpful for thinking through certain telehealth protections.

Of note, **Marjorie Ginsburg, BSN, MPH** expressed a largely dissenting opinion, expressing skepticism around widespread use of telehealth and contesting that "we can put the genie back in the bottle." Appealing to MedPAC's commitment to making evidence- and value-driven decisions, she asserted there is not yet enough information to be able to decide whether telehealth should be universally available across the Medicare FFS program. Instead, she was more comfortable testing greater access to telehealth in the context of two-sided alternative payment models (APMs) rather than spreading access throughout the FFS market. **Bruce Pyenson** said he was "sympathetic to [Ms. Ginsburg's] point of view."