



REPORT

Telehealth During a Time of Crisis: Medicare Experiences Amid COVID-19

JULY 2020

BETTER MEDICARE
ALLIANCE

Center for Innovation
in Medicare Advantage

Analysis by ATI Advisory

OVERVIEW AND PURPOSE

The Center for Innovation in Medicare Advantage, the 501(c)(3) sister organization to Better Medicare Alliance, partnered with ATI Advisory to conduct a study on the role of telehealth and virtual care in meeting the needs of Medicare beneficiaries during the Coronavirus (COVID-19) public health emergency. COVID-19 has placed immense pressure on the health care delivery system with some providers strained beyond capacity and almost all having to pause non-COVID services entirely.

The virus has challenged health care payers and providers to address new and urgent demands, creating misalignment in supply, demand, and expertise across provider types, facility types, and state lines. It has also created the need for new and innovative approaches to serving individuals in their homes, particularly for seniors who have been considered at greatest risk.

Policy waivers from the Centers for Medicare and Medicaid Services (CMS) and Congress during the public health emergency have allowed telehealth to expand rapidly. Study findings suggest Medicare Advantage plans and risk-bearing providers were strongly positioned to deploy solutions that connect Medicare beneficiaries with essential services. While the COVID-19 crisis created the engine for dramatic uptake of telehealth, longstanding Traditional Fee-for-Service (FFS) Medicare restrictions have prevented telehealth from reaching its full potential even during the public health emergency. Given these findings, there are opportunities for CMS and Congress to consider policy changes moving forward.

The authors acknowledge that the pandemic is ongoing, and it is affecting geographies and demographic groups differently. In particular, the public health emergency is casting a clear light on the disproportionate impact on minority communities, those in institutional settings, and those with certain co-morbidities. This report offers findings from the first months of the pandemic as a way to gain early lessons learned on the urgent response that led to broad adoption of telehealth. Through data analysis and stakeholder interviews, ATI Advisory identified factors accelerating delivery of telehealth in the new environment, and barriers to fulfilling its full potential:

Telehealth Accelerators	Telehealth Barriers
<ul style="list-style-type: none">• Flexibility under risk-based payment• Allowing home-based telehealth• Removing prior relationship requirements• Expanding providers and services eligible for payment	<ul style="list-style-type: none">• Traditional FFS prohibitions• Interaction between Medicare and Medicaid• Beneficiary access to devices and data• Process rigidity

Policymakers should leverage experiences and lessons learned during the public health emergency to improve the health care delivery system, specifically with a focus on the role telehealth and virtual care should play moving forward. Key to this is the permanent authorization of many of the policy waivers permitted during the COVID-19 public health emergency.

BACKGROUND – TELEHEALTH AND VIRTUAL CARE POLICY

DEFINITIONS

In Medicare, a “telehealth service” is defined in statute as a “professional consultation, office visit, and office psychiatry service, and any additional service specified by the Secretary.”¹ In recent guidance from the administration, CMS describes telehealth as “the exchange of medical information from one site to another through electronic communication to improve a patient’s health.”² Medicare also allows limited virtual care delivery beyond the formal telehealth definition to include these definitions:

Telehealth Visit:

Visit with a provider that uses telecommunications systems between a provider and a patient

Virtual Visit:

Brief (5-10 minutes) check-in with a practitioner via telephone, or other telecommunications device, to decide whether an office visit is needed

E-Visit:

Communication between a patient and their provider through an online patient portal

Asynchronous Service (Store and Forward):

Transmission of recorded health history (e.g., retinal scanning, digital images) through a secure electronic communications system to a practitioner for evaluation

Remote Patient Monitoring:

Utilization of digital technologies to collect medical, and other forms of, health data from individuals in one location to electronically transmit to health care providers

MEDICARE TELEHEALTH POLICY PRIOR TO THE COVID-19 PUBLIC HEALTH EMERGENCY

Prior to the COVID-19 public health emergency, Medicare coverage of telehealth and asynchronous services generally were limited in Traditional FFS Medicare by several parameters (Figure 1). Other virtual care methods were subject to alternate restrictions such as having an established patient-provider relationship prior to rendering a virtual service (in the case of E-visits). For this report, telehealth refers to services covered by a ‘Medicare Telehealth Visit’. Virtual care is broader and captures telehealth as well as services not classified as a Medicare Telehealth visit, such as (but not limited to) virtual visits, E-Visits, telephonic Evaluation and Management (E/M) services, or remote patient monitoring.

FIGURE 1. TELEHEALTH LIMITATIONS IN TRADITIONAL FFS MEDICARE

Parameter	Limitations Prior to Public Health Emergency Waivers
ORIGINATING SITE: The location of the beneficiary receiving services through a telecommunications system	<p>Limited to rural health professional shortage areas (HPSAs) and counties located outside metropolitan statistical areas, and specific health care facilities and provider offices:</p> <ul style="list-style-type: none"> • Physician/practitioner offices • Hospitals • Critical Access Hospitals (CAH) • Rural Health Clinics • Federally Qualified Health Centers • Hospital-based or CAH-based Renal Dialysis Centers (including satellites) • Skilled Nursing Facilities • Community Mental Health Centers • Renal Dialysis Facilities • Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis • Mobile stroke units
DISTANT SITE: The location and type of eligible provider rendering the service	<p>Limited to the statutory definition of physician or practitioner:</p> <ul style="list-style-type: none"> • Physicians • Nurse practitioners • Physician assistants • Nurse-midwives • Clinical nurse specialists • Certified registered nurse anesthetists • Clinical psychologists and clinical social workers • Registered dietitians or nutrition professional
MODALITY: The method of providing virtual services	<p>Limited to interactive audio and video telecommunications systems that allow real-time communication between the originating site and distant site, and available for 103 service codes.³ Asynchronous services reimbursable only when provided in Alaska and Hawaii.</p>

Medicare Advantage plans must cover all benefits included in Traditional FFS Medicare and can expand telehealth and virtual care services beyond the limitations of the originating site, distant site, or modality/service restrictions listed above. Until 2019, Medicare Advantage plans choosing to allow telehealth for services beyond those permitted in Traditional FFS Medicare were required to do so as a supplemental benefit. Beginning in 2019, Medicare Advantage plans were able to provide “additional telehealth benefits” (beyond what is allowed in Traditional FFS Medicare) as a core benefit, rather than as a supplemental benefit.

TELEHEALTH POLICY WAIVERS DURING THE PUBLIC HEALTH EMERGENCY

As part of the response to the public health emergency, CMS issued numerous waivers during March and April 2020 allowing significant telehealth flexibility in the Medicare program. These waivers generally expanded who can provide telehealth, where it can be provided, and how it can be provided (Figure 2). These temporary changes have increased access to telehealth among the Medicare population. Data from CMS show a dramatic increase of more than 12,000% in those using telehealth services, from 13,000 Traditional FFS Medicare beneficiaries per week before the public health emergency to 1.7 million beneficiaries at the end of April.⁴

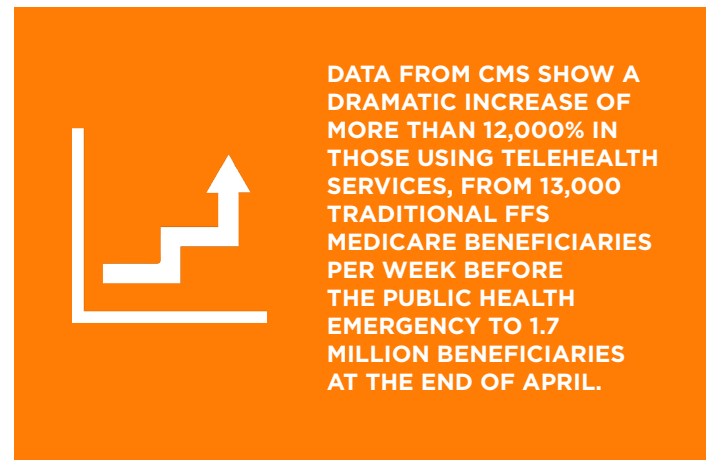


FIGURE 2. TELEHEALTH AND VIRTUAL CARE POLICY WAIVERS DURING COVID-19



STUDYING TELEHEALTH DURING COVID-19

Better Medicare Alliance partnered with ATI Advisory (ATI) to conduct a study on the initial and early experiences of a wide range of stakeholders in deploying telehealth and virtual care to preserve Medicare beneficiary access to care during the COVID-19 public health emergency. ATI completed quantitative and qualitative analyses:

1. 2017 Medicare Current Beneficiary Survey (MCBS) data were used to quantify community-based Medicare beneficiary access to internet services by age, urbanicity, income level, and Medicare Advantage enrollment.ⁱ
2. Interviews were conducted with a broad range of Medicare Advantage and telehealth stakeholders, including national, regional, and local Medicare Advantage plans; Medicare providers spanning service types (primary care, physical/occupational/speech therapy, non-medical) and serving both Traditional FFS Medicare and Medicare Advantage beneficiaries; telehealth vendors; and, telehealth policy experts. A total of 17 interviews were completed between April 28 and June 16, 2020 (Figure 3).



FIGURE 3. NUMBER OF INTERVIEWEES BY STAKEHOLDER CATEGORY

Category	Number of Interviewed Organizations ⁱⁱ
Medicare Advantage Plan	6
Medicare Provider	7
Telehealth Vendor	5
Policy Expert	3

ⁱ The MCBS does not directly address whether beneficiaries have access to internet in the home, but the survey does ask beneficiaries how frequently they use the internet, either on their own or with the help of another individual.

ⁱⁱ Four organizations were counted in both the Medicare Advantage Plan and Medicare Provider categories because they operate as both ("Payvider") and provided distinct perspectives as each type of stakeholder.

FINDINGS

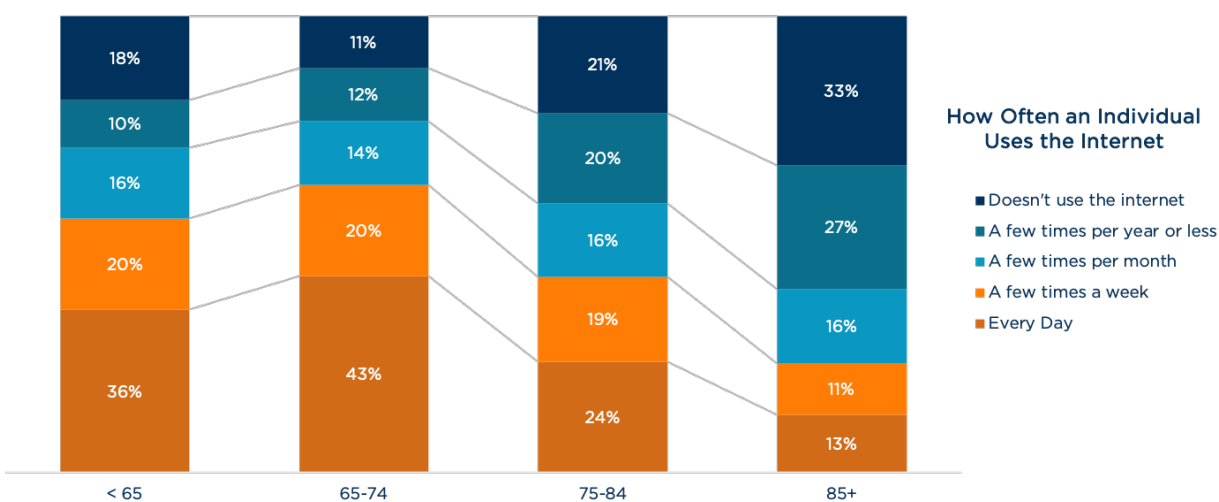
ACCESS TO INTERNET

Internet use among Medicare beneficiaries varies considerably based on an individual's age, income, and the rural/urban nature of where they live.ⁱⁱⁱ Analysis also showed a small difference in reported internet use, most notably in their everyday use, between beneficiaries enrolled in Medicare Advantage compared with beneficiaries in Traditional FFS Medicare.⁵ Taken together, these findings are important as policymakers look to telehealth and virtual care as a means to improve access to care among disadvantaged populations.

AGE

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FIGURE 4. MEDICARE BENEFICIARY INTERNET USE BY AGE



ⁱⁱⁱ Figures 4-7 in this report include Medicare beneficiaries residing in the community. Unless otherwise noted (Figure 7), data in these Figures combine Medicare Advantage and Traditional FFS Medicare beneficiaries.

INCOME

Internet use among Medicare beneficiaries increases as income level increases. Only 32 percent of Medicare beneficiaries under 100 percent of the federal poverty level^{iv} (FPL) reported frequent internet use compared with 78 percent of Medicare beneficiaries at or above 400 percent FPL (Figure 5). Among these two extremes in income, low income Medicare beneficiaries are seven times more likely than higher income beneficiaries to report no internet use, at 34 percent and 5 percent (respectively).

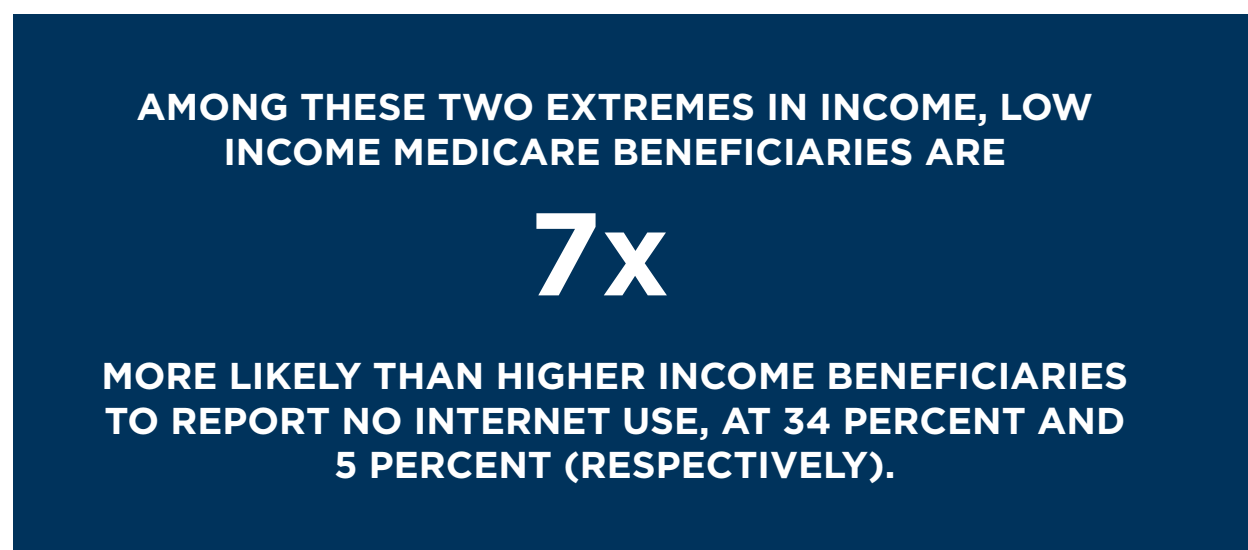
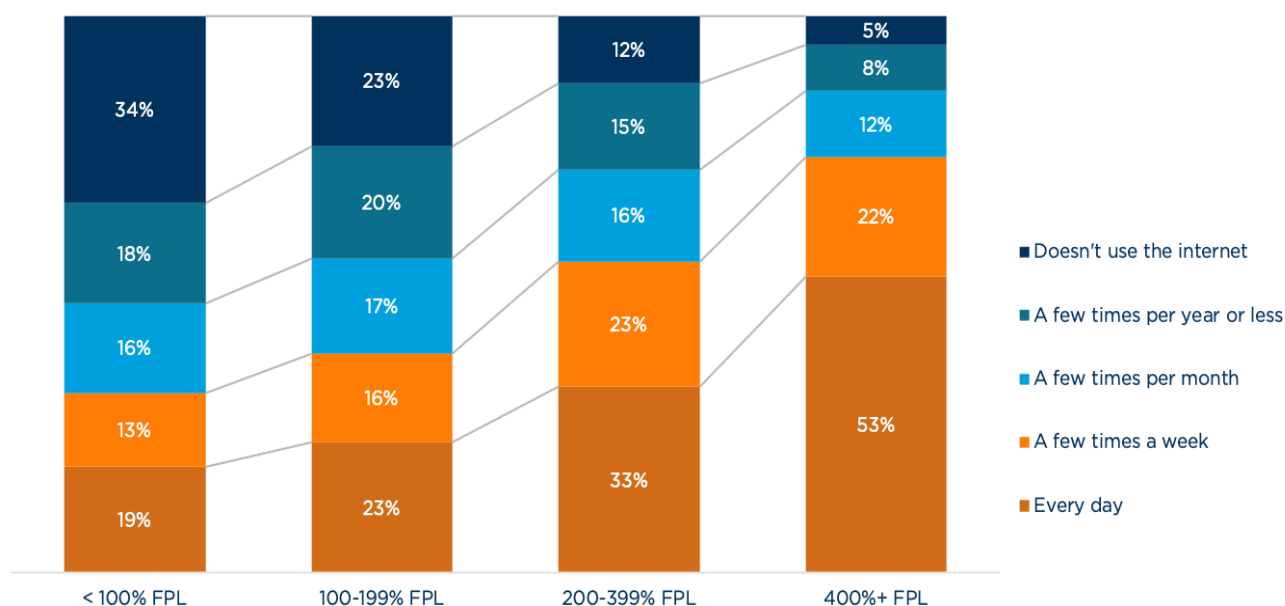


FIGURE 5. MEDICARE BENEFICIARY INTERNET USE BY INCOME LEVEL

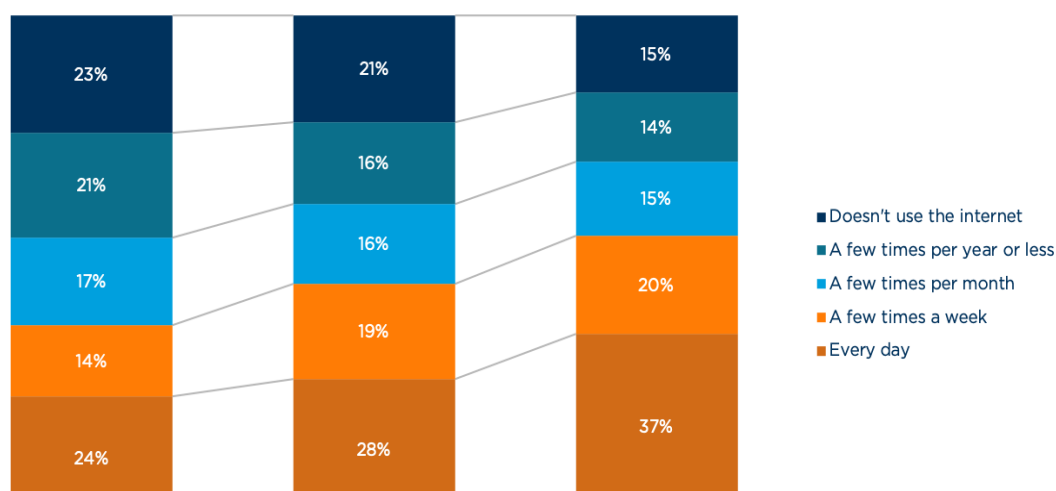


^{iv} In 2017, the Federal Poverty Level was \$12,060 for one person and \$16,240 for a couple.

URBANICITY

Medicare beneficiaries residing in rural areas are less likely to report internet use than beneficiaries in more urban settings. 38 percent of beneficiaries in rural areas using the internet several times per week or daily, compared with 57 percent of beneficiaries in metro/urban areas (Figure 6). Further analysis showed this same trend when comparing within all income levels and age cohorts. For example, among those earning less than 100 percent FPL or among those aged 65-74, Medicare beneficiaries in metro/urban areas are more frequent users of the internet when compared with Medicare beneficiaries in less urban areas (data not shown).

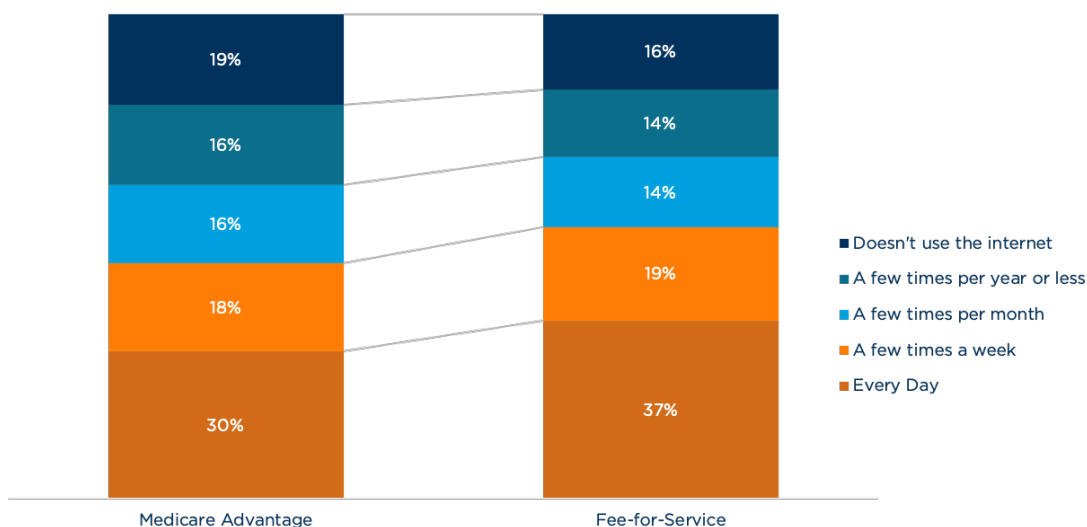
FIGURE 6. MEDICARE BENEFICIARY INTERNET USE BY URBANICITY



PROGRAM PARTICIPATION

Medicare beneficiaries participating in Traditional FFS Medicare use the internet more often than those enrolled with Medicare Advantage, with 56 percent and 48 percent respectively, using the internet daily or several times per week (Figure 7). This difference holds true when accounting for urbanicity, age, and among lower-income (<200 percent FPL) beneficiaries (data not shown).

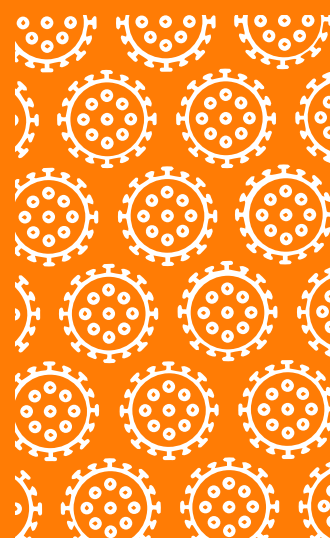
FIGURE 7. MEDICARE BENEFICIARY INTERNET USE BY PROGRAM ENROLLMENT



STAKEHOLDER EXPERIENCES DURING COVID-19 PUBLIC HEALTH EMERGENCY

In directed, one-on-one structured interviews, interviewees shared their experiences and insights regarding telehealth and virtual care prior to and during COVID-19. They specified what factors influenced implementation and expansion, as well as resulting beneficiary experiences (Figure 8). Two key themes emerged consistently:

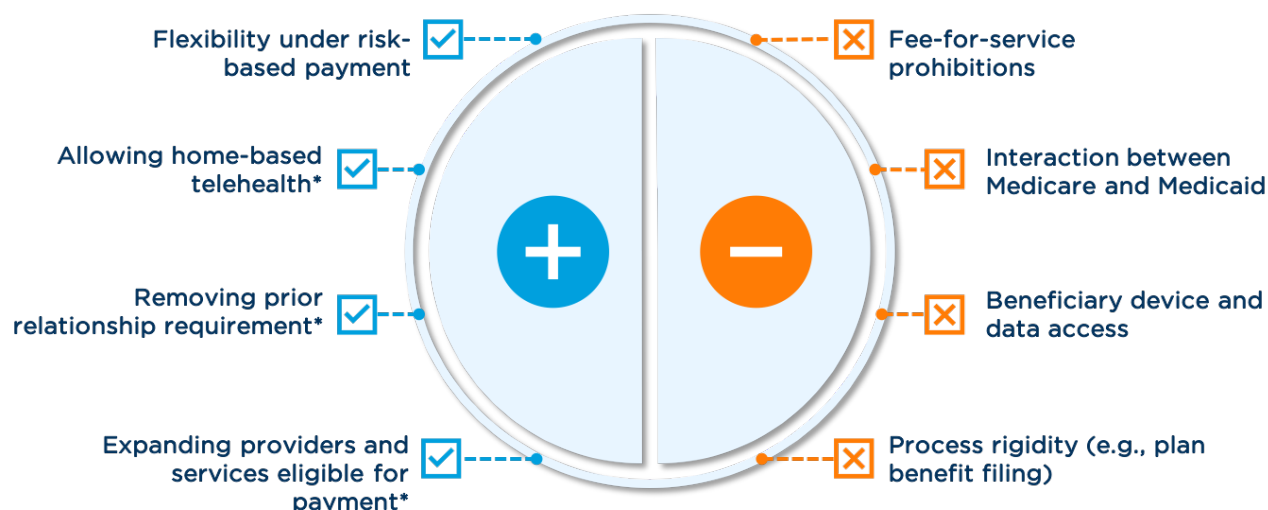
1. **Risk-bearing payment arrangements** allowed plans and providers to act nimbly and meet evolving Medicare beneficiary needs during the public health emergency and **facilitated telehealth implementation and expansion** during the COVID-19 public health emergency.
2. **Traditional FFS Medicare policies** have slowed the uptake of telehealth generally, and served as a **barrier to telehealth implementation and expansion** during the COVID-19 public health emergency both in practices with only Traditional FFS Medicare beneficiaries and for those in practices with a mix of Traditional FFS Medicare and Medicare Advantage beneficiaries.



Other themes centered around beneficiary access to and understanding of technology, interactions between Medicaid and Medicare, and Medicare Advantage benefit design.

FIGURE 8. INFLUENCES ON TELEHEALTH AND VIRTUAL CARE DURING COVID-19

ACCELERATORS



BARRIERS

*Denotes a COVID-19 public health emergency policy waiver that contributed to virtual care acceleration

TELEHEALTH AND VIRTUAL CARE ACCELERATORS

Given the rapid nature of business closures and stay-at-home orders issued during the public health emergency, plans and providers had to shift to virtual care delivery almost immediately to preserve Medicare beneficiary access to care. Most plan and provider interviewees had existing telehealth infrastructure prior to the start of the COVID-19 pandemic, but only a small fraction of visits were delivered using virtual care before March 2020.

Flexibility Under Risk-based Payment

Plans and providers who were able to rapidly expand telehealth and virtual care delivery credited risk-bearing payment arrangements as a key factor:

- Providers pointed to risk-bearing relationships with Medicare Advantage plans as a main driver in their ability to scale virtual care for Medicare patients. Providers reported using the flexibility of capitated payments to deploy solutions to all Medicare patients. This was regardless of whether the beneficiary was in Medicare Advantage or Traditional FFS Medicare, and included providing devices to some patients to facilitate telehealth services. Providers also reported that Medicare Advantage capitated payments allowed them to implement and expand solutions without having to wait for fee-for-service policy waivers to “catch-up” to Medicare Advantage.
- Medicare Advantage plans reported leaning on the flexibility of quality improvement activities, clinical model approaches, and administrative dollars during the COVID-19 public health emergency to provide rapid access to telehealth to beneficiaries. One large Medicare Advantage plan reported loaning 50,000 tablets to members to allow access to telehealth using a clinical home monitoring program to deploy devices and services.

Allowing Home-based Telehealth

The ability to use “home” as the originating site has been essential for maximizing beneficiary access during the COVID-19 public health emergency. While Medicare Advantage plans were able to offer telehealth in the home prior to the public health emergency, as discussed more below, plans reported that the waiver of the Traditional FFS Medicare originating site policy increased the likelihood providers were willing and able to support telehealth and virtual care.

Removing Prior Relationship Requirements

While early legislation during the public health emergency expanded telehealth, it added “qualified provider” language restricting Medicare telehealth encounters to beneficiaries with an existing relationship with the rendering provider. These prohibitions effectively excluded individuals new-to-Medicare from receiving telehealth services during the COVID-19 public health emergency and also added administrative burden to providers before they could render services and prevented many telehealth vendors from serving beneficiaries.

CMS subsequently released guidance that no audits would be conducted to confirm a prior relationship for telehealth claims submitted during the public health emergency which indirectly lifted these restrictions. Allowing Medicare beneficiaries to receive telehealth services from providers regardless of a prior relationship maximized the ability for Medicare Advantage plans and providers to “provide access at a desperately needed time,” as noted by one organization. This policy flexibility allowed Medicare Advantage plans to expand beneficiary access and overcome the lack of telehealth infrastructure among some network providers. It also permitted Medicare Advantage plans to rely on telehealth vendors with broad provider relationships nationwide.

Expanding Providers and Services Eligible for Payment

Telehealth provisions associated with the Social Security Act §1834(m), including originating site restrictions, distant site and provider type restrictions, and limits on allowable services through telehealth have a significant impact on beneficiary access. CMS' waiver of these provisions during the COVID-19 pandemic led to the expansion of telehealth to more geographies, additional provider types, additional services, and as a result, more beneficiaries.

- Expansion of distant site requirements to include clinics, both Federally Qualified Health Centers and Rural Health Clinics, expanded access to vulnerable and lower income individuals. However, payment for these provider types under telehealth is not commensurate with typical prospective payment or all-inclusive rates.
- Allied health professionals (e.g., physical, occupational, and speech therapists) have had successes with telehealth during the COVID-19 public health emergency, but they acknowledged limits on the types of services impacted the services that can be provided virtually.
- Cross-state provision of services is important to align supply and demand and relaxing in-state licensure requirements during the public health emergency maximized this alignment.^v

TELEHEALTH AND VIRTUAL CARE BARRIERS

Longstanding Traditional FFS Medicare policy barriers and Medicare Advantage bid process requirements contributed to a lack of infrastructure among providers and some Medicare Advantage plans, detailed below. These barriers, coupled with beneficiary access to the Internet and devices, slowed the implementation and expansion of telehealth for some organizations.

Traditional FFS Medicare Prohibitions

Although policy waivers related to §1834(m) of the Social Security Act, i.e., originating site including urbanicity, distant site/provider type, and types of services, allowed for the expansion of telehealth during the COVID-19 public health emergency. Prior to these waivers, the §1834(m) restrictions, i.e., limitations of types of providers, impeded telehealth growth. Before the public health emergency, providers were not incentivized to invest in telehealth infrastructure because the service was reimbursable for only a small portion of their patient panel (i.e., only those beneficiaries enrolled in Medicare Advantage), and providers were unlikely to recover their investment. Providers are also unlikely to modify practice patterns based on a single payer; as a result, telehealth would need to be normal scope of practice for all patients, not just those enrolled with Medicare Advantage plans, before providers were willing to invest.

Some Medicare Advantage plans reported including limited telehealth benefits in their annual bid submissions to CMS due to Traditional FFS Medicare prohibitions and challenges. This included uncertainty regarding Traditional FFS Medicare telehealth fee schedules, misaligned Traditional FFS Medicare payment policies, and lack of network providers investing in telehealth infrastructure. As a result, some Medicare Advantage plans have been hesitant to expand telehealth benefits beyond what is permitted in Traditional FFS Medicare.

Taken together, provider and Medicare Advantage plan reactions indicate that Traditional FFS Medicare telehealth restrictions slowed the growth of telehealth prior to the COVID-19 public health emergency and subsequently created delays in expanding telehealth at the beginning of the public health crisis for many organizations.

^v Cross-state provision of telehealth services is not specific to §1834(m) and access was based on state waivers during the public health emergency.

Interaction between Medicare and Medicaid

Providers and plans serving beneficiaries dually eligible for Medicare and Medicaid (“dual eligibles”) provided insights on their experiences navigating existing policies and policy waivers across the two programs during the public health emergency. Telehealth experiences vary by state due to the timing of state Medicaid waiver approvals, Medicaid program face-to-face requirements, and the degree of integration between the Medicare Advantage plan and provider. Generally, the intersection of Medicaid and Medicare policy created barriers for organizations attempting to implement or expand access to telehealth services for dual eligibles. Barriers to telehealth included:

- Given their socioeconomic status, dual eligibles are likely to have limited access to appropriate technology devices that accommodate telehealth. In some instances, those with cell phones may be unwilling to use their limited minutes or data to interact with providers or health plans, particularly when they receive multiple touchpoints due to misalignment in Medicare and Medicaid program requirements.
- An organization with significant Medicare-Medicaid integration reported that it was challenging to find vendors able to integrate and meet integration requirements, across Medicare and Medicaid services, payment, and policy.
- Plan of Care requirements in Medicaid long-term services and supports (LTSS) programs severely limited flexibility to render services virtually or to modify the frequency of interactions with beneficiaries. Depending on the timing of state submission and CMS approval of Medicaid 1135 waivers and state plan amendments during the public health emergency (e.g., Social Security Act §1915(c) Appendix K), Medicaid policy for dual eligibles did not always keep pace with Medicare waivers. This resulted in providers and Medicare Advantage plans maintaining face-to-face interactions, such as patient monitoring and assessments, with dual eligibles during the COVID-19 public health emergency that could have been completed virtually.

Beneficiary Device and Data Access

Medicare beneficiaries’ access to appropriate devices prevented faster and broader expansion of telehealth during COVID-19. Many organizations including Medicare Advantage plans and providers loaned tablets to Medicare beneficiaries during the public health emergency to enable utilization of telehealth services. As noted previously, risk-bearing contracts enabled this flexibility. CMS allows remote access technology such as cellular data and electronic devices as a Medicare Advantage supplemental benefit.

During the public health emergency, CMS is also allowing Medicare Advantage plans to make mid-year supplemental benefit changes to address evolving beneficiary needs. However, Medicare Advantage plans must limit the remote access technology benefit to primarily health related activities (e.g., locking a device beyond interaction with a provider) or with the expectation that it improves or maintains health or overall function for individuals with a specific chronic condition.^{vi} Multiple Medicare Advantage plans reported that these limitations prevented them from using the remote access technology benefit to provide devices to Medicare beneficiaries and that they instead leaned on clinical models to help provide access during the COVID-19 public health emergency.

“One of our provider clients surveyed Medicare patients and only 50% have any cell phone – not even a smart device.”

Vendor Interviewee

^{vi} Medicare Advantage plans can offer special supplemental benefits to the chronically ill (SSBCI), which are benefits that do not have to be primarily health related in nature. However, SSBCI must be limited to individuals with a pre-specified chronic condition, identified when a plan files its bid to CMS.



Process Rigidity

In addition to limitations in use of remote access technology supplemental benefits, the rigidity of the benefit and bid submission process is another barrier to telehealth. Specifically, CMS requires Medicare Advantage plans to identify which services will be offered via telehealth during the annual bid process. Plans are subsequently limited to allowing telehealth for only those previously identified services.

Plans reported basing their telehealth benefit filing on the known capabilities of local providers and selecting only those services that they were certain providers would have the infrastructure to provide. While CMS waived this limitation during the COVID-19 public health emergency, Medicare Advantage plans expressed concerns that their contract year 2021 bids, submitted to CMS in early June 2020, would not reflect the new providers in their network with telehealth capabilities.



BENEFICIARY EXPERIENCES AND PREFERENCES

Among Medicare beneficiaries using telehealth and virtual services during the COVID-19 public health emergency, plan- and provider-issued surveys indicate beneficiary satisfaction with care that mirrors pre-COVID-19 levels. In some instances, satisfaction exceeded pre-COVID-19 levels. These reports are consistent with a recent survey that found 91 percent of seniors had a favorable telehealth experience and 78 percent were likely to use telehealth again. Medicare beneficiaries reportedly appreciated the efficiency and convenience of accessing care from the home.

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Interviewees shared specific details on Medicare beneficiary experiences that reflected three broad categories: demographics, modality, and access (Figure 9).

FIGURE 9. MEDICARE BENEFICIARY EXPERIENCES WITH TELEHEALTH AND VIRTUAL CARE

Demographics	<ul style="list-style-type: none">• Beneficiaries with English as a second language were more comfortable with informal platforms (e.g., Skype, FaceTime)• Up to 50% of older Medicare beneficiaries are without cell phones, and a substantial portion are without Wi-Fi or internet at home• Geography at the state level has an impact on uptake but is not clearly aligned with rural versus urban, which was also indicated by CMS' analysis finding regional variation across states but limited variation by urbanicity.⁹
Modality	<ul style="list-style-type: none">• Audio is highly preferred, with several interviewees suggesting greater than 60% of beneficiaries choose this modality• Beneficiaries perceive video as invasive and are sensitive about their personal appearance and the cleanliness of their home• Among those with devices, the preference is for mobile devices over personal computers• Beneficiaries are highly receptive to text messaging approaches
Access	<ul style="list-style-type: none">• Lower-income beneficiaries with cell phones are not willing to use cell phone minutes• Video-enabled and "smart devices" are uncommon among beneficiaries• Beneficiaries appreciate the convenience of vendor models with non-networked providers but prefer continuity of care with existing providers



Utilization

Consistent with data from CMS, plans and providers report that the COVID-19 public health emergency has led to significant increases in telehealth and virtual care utilization. The amount of increase varies based on specialty type, telehealth infrastructure prior to the COVID-19 public health emergency, and geography.

Of note, virtual care has increased access to behavioral health services resulting in a reduction in behavioral health no-shows because of the convenience associated with receiving virtual care in the home. Behavioral health telehealth utilization also reportedly grew more than other services during the COVID-19 public health emergency. CMS data showed that 60 percent of Medicare mental health services with psychologists and psychiatrists were provided through telehealth.¹⁰



Key utilization examples shared by interviewees include the following:

- A telemedicine vendor reported a 22-fold increase among its providers
- One Medicare Advantage plan with existing infrastructure reported a 4-fold increase in utilization
- An in-home provider reported 25 percent of visits shifted to virtual
- A primary care provider reporting 90 percent of pre-COVID-19 volume shifted to virtual care, with 30 percent provided via video
- A payvider reported growth from 100 visits per week to 10,000 per week

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OPPORTUNITIES AND RECOMMENDATIONS

The COVID-19 public health emergency has had devastating impacts on the Medicare population, with over 320,000 Medicare beneficiaries diagnosed as of May 16, 2020, 109,000 hospitalized, and 28 percent of those hospitalized with the virus dying.¹¹ These are sobering statistics and the public health emergency persists.

Figure 10. Opportunities to Promote Telehealth Post-COVID-19



In spite of the suffering this pandemic has caused, there are experiences coming out of the public health emergency that can be used to improve the health care system and increase access to care, including the continued use of telehealth and virtual care. To start, CMS and Congress should allow for continued flexibility in the provision of telehealth services to Medicare beneficiaries, focused on improving access, process, and payment policies for telehealth services (Figure 10). This should be approached with guiding principles that allow for flexibility for Medicare Advantage plans and providers, coupled with appropriate levels of accountability that preserve and expand access to quality care.

Numerous telehealth policies in place prior to the public health emergency create barriers to telehealth that may inadvertently decrease access for all Medicare beneficiaries, and in particular the most vulnerable—those with behavioral health needs, the inability to leave their homes, or without access to internet or video-enabled devices. The telehealth environment is evolving rapidly and will continue to evolve as an important resource for providers and beneficiaries as COVID-19 remains a shared public health crisis. Policies should promote the expanded use of telehealth for Medicare beneficiaries, and not prevent or inhibit Medicare Advantage plans and providers from providing a timely response or expanding access to care.

The following are recommendations for consideration based on the study findings above.



ACCESS

RECOMMENDATION: §1834(M) PROVISIONS IN THE SOCIAL SECURITY

CMS and Congress should consider the shifting influence of Traditional FFS Medicare policies based in §1834(m) on the uptake of telehealth among Medicare providers and Medicare Advantage plans. The policies create inequity for beneficiaries based on where they live, their access to transportation, and the services they require. Recommended updates to this policy include:

- **Elimination of originating site requirements, or expanding originating site locations to include the home**
- **Expansion of geographies to include all counties, not just those located outside metropolitan statistical areas or in health professional shortage areas**
- **Expansion of qualified distant site providers to include allied health professions, Federally Qualified Health Centers, and Rural Health Clinics, and allow for services to be reimbursable without a prior provider relationship**

CMS should couple the permanent elimination of these provisions with Traditional FFS Medicare payment models that encourage provider uptake while preventing growth in overall Medicare utilization.

RECOMMENDATION: VIRTUAL HEALTH MODALITIES

Telehealth is defined differently by state and federal policymakers, as the provision of virtual services is expanding and new technologies emerge. Additionally, many Medicare beneficiaries do not have access to interactive telehealth technology as traditionally defined. **CMS should consider permanently expanding services allowed through modalities such as audio-based and asynchronous technologies. CMS should also identify services that are effectively provided with audio alone and align audio and video payment for these services** to encourage efficient use and curb unnecessary growth in overall utilization.

PROCESS AND PAYMENT

RECOMMENDATION: MEDICARE ADVANTAGE BID PROCESS

CMS should consider the capacity for Medicare Advantage plans to innovate as providers build infrastructure for telehealth and as beneficiary demand for virtual services grows.

The requirement for Medicare Advantage plans to specify exact services allowed via telehealth as part of the bid process, six months in advance of a contract year, and be limited to those services through the subsequent contract year prevents innovation and may limit beneficiary access. Allowing broader definition of services and flexibilities for modification prior to or during the contract year would alleviate this limitation.

RECOMMENDATION: MEDICARE FEE SCHEDULES AND FEE-FOR-SERVICE PAYMENT MODELS

Fee-for-service payment policy and fee schedules have created confusion and inefficiency among Medicare Advantage plans and providers aiming to implement and expand access to telehealth. **Updating fee-for-service payment approaches would promote appropriate growth in telehealth.**

- CMS should modify Traditional FFS Medicare fee schedules to reflect growing telehealth and virtual care delivery, which ensures services are not reimbursed twice due to having a virtual and in-person component.
- Payment for telehealth should be on par with in-person services as appropriate so as not to discourage its use.

RECOMMENDATION: RISK ADJUSTMENT

As utilization for Medicare beneficiaries shifts increasingly toward virtual care, risk adjustment should accommodate beneficiary preferences to ensure Medicare Advantage plans and providers are reimbursed at a rate appropriate to the complexity of the beneficiaries they serve. **CMS should allow virtually-informed risk adjustment with certain guardrails.**



DISCUSSION

Telehealth and virtual care have advanced dramatically as a result of the public health emergency, with risk-bearing providers and Medicare Advantage plans at the forefront of the expansion. The innovation and access realized from this growth should be permitted to continue. Face-to-face care is important and often essential, and policymakers should continue to seek ways to improve access to in-person services. However, certain services can be provided effectively through telehealth and virtual methods. By expanding these channels of health care delivery, more Medicare beneficiaries may have access to needed care in ways that are more convenient, less costly, and well-suited to certain individuals, conditions, or treatments. Medicare beneficiaries should not be disadvantaged due to long-standing, telehealth prohibitions that lead to access inequities. The expanded policies during the COVID-19 public health emergency, including audio as a reimbursable telehealth modality, have resulted in similar rates of access regardless of age demographic, race/ethnicity, income level, and urbanicity.¹²

There are concerns that a blanket expansion of virtual care could lead to an overall increase in Medicare services and costs; but if coupled with clear guidance on payment, evidence-based clinical judgment, and quality measures, CMS could mitigate the potential for inappropriate utilization and improve access to telehealth. Additionally, the potential to increase access to preventive services and care management and decrease behavioral health “no-shows” could decrease avoidable inpatient admissions.

At time of publishing this report, numerous legislative proposals have been introduced in Congress to expand, study, or make permanent changes to telehealth. The [“Protecting Access to Post-COVID-19 Telehealth Act,”](#) introduced in the Congressional Telehealth Caucus, removes the originating site requirement for Medicare beneficiaries, as well as extends telehealth reimbursement following the public health emergency.¹³ Other bills, such as the [“HEALTH Act of 2020,”](#) would expand telehealth reimbursement for RHCs and FQHCs.¹⁴ In addition to these bipartisan efforts, Congress has submitted several letters to the Department of Health and Human Services (HHS) for action,¹⁵ and states have taken action to reinforce telehealth. ^{vii}

**“In total,
over 9 million
beneficiaries
have received
a telehealth
service
during the
public health
emergency”**

Seema Verma

In concert with legislative action, CMS should continue the new momentum that has fostered innovation and access to care. Preserving telehealth and virtual care flexibilities is necessary to encourage provider investment in virtual care delivery channels. Policymakers have an opportunity to expand access to care to individuals unable or unwilling to leave their homes, or who prefer or would benefit from the convenience of in-home services. Health care policy should keep pace with technology innovations and solutions that have the potential to improve efficiencies while also improving outcomes and well-being. Findings from this study suggest there are several opportunities for Congress and CMS to consider as they modernize health care policy in an effort to maximize access to needed and appropriate care.

^{vii} Examples include Idaho Governor Little signing an executive order to preserve telehealth flexibilities that were authorized during the public health emergency, Vermont authorizing telemedicine and store-and-forward services until 2021, and Kansas allowing physicians from out-of-state to provide telemedicine for certain circumstances. Similar measures have been introduced in other states including New York, Colorado, and Tennessee to remove barriers to telehealth or increase telehealth reimbursement.

SOURCES

¹ Social Security Act, Sec. 1834 (m)(F)(i)

² <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet#:~:text=Telehealth%2C%20telemedicine%2C%20and%20related%20terms,provision%20of%20healthcare%20is%20increasing>

³ <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

⁴ <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

⁵ Medicare beneficiaries residing in the community; 2017 Medicare Current Beneficiary Survey

⁶ H.R. 6074, Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020

⁷ For additional detail on Medicaid authorities during the COVID-19 public health emergency, see COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies, available at <https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf> (updated as of June 30, 2020 at the time this report was published)

⁸ <https://www.bettermedicarealliance.org/news/poll-seniors-give-telehealth-high-marks-medicare-advantage-satisfaction-smashes-new-record/>

⁹ <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

¹⁰ <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

¹¹ <https://www.cms.gov/research-statistics-data-systems/preliminary-medicare-covid-19-data-snapshot>

¹² <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>

¹³ <https://mikethompson.house.gov/sites/mikethompson.house.gov/files/2020-07-15ProtectingAccessToPost-COVID19TelehealthAct.pdf>

¹⁴ <https://www.congress.gov/116/bills/hr7187/BILLS-116hr7187ih.pdf>

¹⁵ <https://www.cassidy.senate.gov/imo/media/doc/LTO.%202020.7.2.%20Smith%20Cassidy%20Telehealth%20Letter-2.pdf>