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Health Issue Brief

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Medicare Payment for Telehealth

Early in the COVID-19 public health emergency, the Centers for Medicare & Medicaid Services (CMS) expanded coverage of telehealth services delivered by allowed providers in Medicare Advantage and Original Medicare.[1] This move simplified continuity of care for Medicare beneficiaries and encouraged wide use of telehealth services in both programs. As a result, telehealth has become a common method of delivering health services to Medicare beneficiaries. In this brief, we discuss the use of telehealth services both before and during the public health emergency, patterns of use among Medicare beneficiaries, challenges to expanding use of telehealth, and the future of continued payment for these services in Medicare.

About this brief

This brief is one of a series that examines current and emerging issues in the Medicare Advantage program. In 2022, 42 percent of all Medicare beneficiaries—including beneficiaries who are elderly or disabled, and beneficiaries dually eligible for Medicaid—enrolled in one of the more than 3,800 Medicare-approved, private Medicare Advantage plans.

Use of telehealth

Telehealth, also called telemedicine, is the practice of delivering health care services remotely to a patient in another location using audio or video communication. Many providers use videoconferencing software to conduct these services, but telehealth services can also include audio-only visits conducted by telephone.

Historically, federal Medicare regulations governing use of telehealth services limited reimbursement to use for qualified mental health services and prenatal and postpartum care.[2] With respect to qualified mental health services, federal regulations further required that beneficiaries had received a paid or payable in-person item or service from the physician or practitioner delivering the telehealth service within six months of the first mental health telehealth service. To be eligible for reimbursement, telehealth visits for mental health had to take place from a beneficiary's home, rather than from a medical facility. All other covered telehealth visits had to take place in a medical facility.[1,2]

In March 2020, responding to the COVID-19 public health emergency, CMS authorized expanded use of telehealth services for Medicare beneficiaries enrolled in Original Medicare or beneficiaries dually enrolled in Medicare and Medicaid.[3] Under statutory changes authorized by Congress, CMS also allowed Medicare Advantage plans to offer telehealth services to their enrollees. As a result, nearly 52.7 million beneficiaries enrolled in Original Medicare (46.0 percent)[i] and 13.7 million beneficiaries enrolled in Medicare Advantage (43.8 percent) received telehealth services in 2020 (Figure 1).[1,3]

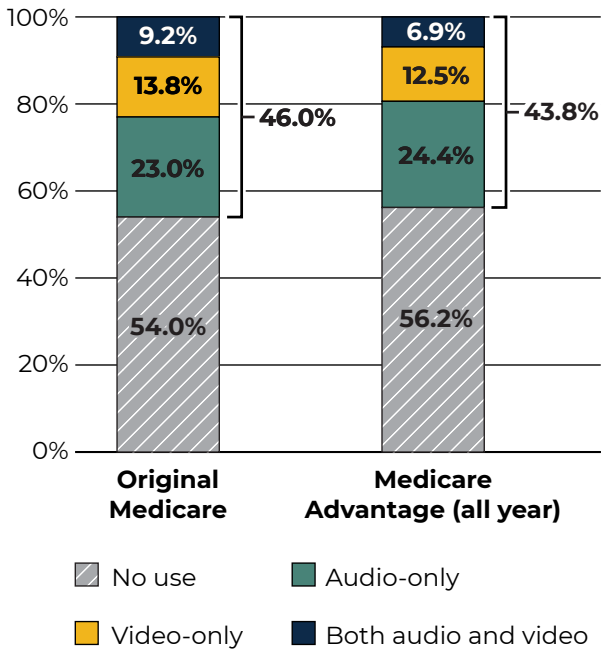
[i] Original Medicare beneficiaries who used telehealth services from mid-March to mid-June 2020 spanned age, racial, and ethnic boundaries in about equal proportions: 30 percent of female beneficiaries and 25 percent of male beneficiaries; 34 percent younger than age 65, 25 percent ages 65 to 74, 29 percent ages 75 to 84, and 28 percent older than 85; and 25 percent Asian beneficiaries, 29 percent Black beneficiaries, 27 percent Hispanic beneficiaries, 28 percent White beneficiaries, and 26 percent reporting belonging to other racial and ethnic groups.[2]

Even before the emergence of COVID-19, many providers and patients had come to prefer audio-only access for some types of care,[4,5] and these visits increased significantly in the early months of the public health emergency. Among Original Medicare beneficiaries, visits with a mental health specialist represented the largest increase in billing of audio-only eligible telehealth services, jumping from 27 percent in 2019 to 70 percent in 2020.[3] Federally qualified health centers and safety net hospitals saw a surge in audio-only services: in 41 federally qualified health centers in California, audio-only visits comprised 65 percent of primary care visits and more than 71 percent of mental health visits in April 2020.[6] One large safety net hospital in Dallas reported handling 4,000 prenatal audio-only visits early in the pandemic.[7]

During the public health emergency, evaluation and management services have become the most common type of service provided via telehealth. From March to July 2020, 38 percent of all Medicare beneficiaries received at least one evaluation and management visit via telehealth.[1] However, telehealth services also remain a mainstay of mental health: 60 percent of Medicare beneficiaries who received mental health services from March to July 2020 received those services via telehealth.[ii] In addition, telehealth, including audio-only visits, has played a large role in the treatment and management of chronic conditions such as diabetes, heart disease, chronic kidney disease, high cholesterol, and hypertension during the public health emergency.[7] Providers have used audio-only visits to follow up on lab and imaging tests, help patients with heart disease adhere to medication regimens, monitor patients who had received a coronary stent placement or after hospitalization for heart failure,[9,10] and triage patients with respiratory symptoms—including suspected COVID-19 cases.[7] In a recent survey conducted to assess patient satisfaction with telehealth, 87 percent of respondents would recommend telehealth, and 73 percent wanted to continue using it after the public health emergency.[11]

Data from the Medicare Current Beneficiary Survey administered in winter 2021 shed light on telehealth use among Medicare beneficiaries. Medicare Advantage beneficiaries (43.8 percent) were slightly less likely to use telehealth than Original Medicare beneficiaries (46.0 percent)[3] and more likely to use audio-only services (24.4 percent versus 23.0 percent) as opposed to video-only or both audio and video (Figure 1).

Figure 1. Telehealth services for beneficiaries enrolled in Medicare in 2020, by program and service delivery type



Source: Medicare Current Beneficiary Survey Winter 2021 Community Supplement public use files, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/MCBS-Public-Use-File.

[ii] An early assessment of the literature published from 2005 to 2016 concluded that audio-only and video-only telehealth services were effective in delivering psychological interventions and served as a critical mode of treatment delivery.[8] Care for four common conditions—depression, post-traumatic stress disorder, anxiety, and adjustment disorders—was delivered effectively using audio-only services. When asked, providers have commented that patients with depression might feel more comfortable talking only by audio (rather than by video), helping them overcome reluctance about therapy.[8]

However, despite evidence indicating it can be an effective mode of care,[5,7-10] telehealth has important limitations. Some services—such as surgery, treatment of trauma, or the delivery of devastating news to patients—require in-person care. And not all evaluation and management services are amenable to effective care via telehealth: vaccinations, screening tests, and assessment of certain skin conditions and musculoskeletal problems also require in-person care. Moreover, care provided only via telehealth raises concern about the quality of care. Providers who rarely see the patient might miss physical signs of a serious diagnosis, such as edema indicating kidney disease or congestive heart failure. Nonverbal cues such as a patient's body language or facial expression, which can be crucial in assessing the patient's emotions, might also be less obvious or not visible via telehealth, impeding providers from gauging whether they are communicating medical information effectively, building rapport, and supporting patients in social isolation.[7]

Challenges to expanding use of telehealth

Despite telehealth's effectiveness in delivering some types of health care and its acceptance by Medicare patients across socioeconomic boundaries, whether these services should continue is the subject of ongoing debate. Much of this debate centers on challenges such as broadband internet access and the potential for fraud.

Broadband access

A significant portion of telehealth visits consist of video communications, which rely on broadband—but not all Americans have access to broadband. Unequal access to broadband raises concerns that providers' increasing use of telehealth could worsen inequities in access to care. In 2021, an estimated 40 percent of adults in the United States with annual household incomes below $30,000 had no home broadband services or did not own a personal computer. Of these, some relied on smartphones for data service, yet about 25 percent of adults with annual household incomes below $30,000 had no smartphone.[12] Even among adults with annual household incomes above $100,000, 1 percent lacked access to home broadband, a smartphone or tablet, or a personal computer.[13] Unpublished data from the University of Michigan indicate that older adults, Black patients, and patients needing an interpreter used audio-only services because they were unable to access video technology or were uncomfortable using it. In tribal communities, where broadband is scarce, about 80 percent of 33,000 telehealth visits provided monthly by the Indian Health Service were audio-only.[7]

Even so, expanded coverage of audio-only visits can help some underserved populations bridge health access gaps, potentially reducing unequal access to care. For example, one recent study concluded that audio-only visits improved access for an estimated 6.3 million older adults who are inexperienced with technology or lack internet access, have visual impairment or disability, or face geographic barriers to access.[14] Of 238 pregnant mothers surveyed in a large safety net hospital in Dallas, 99 percent reported that audio-only visits with an advanced practice nurse met their needs.[5]

Potential for fraud

Concern about the potential for increased fraud, overuse, and abuse also has grown with telehealth's popularity. Some sham telehealth visits with no patient interaction have involved kickbacks to providers writing prescriptions for costly durable medical equipment (DME) such as orthotics and expensive cancer genetic testing.[15] Dozens of DME supply companies established in the names of false owners allegedly submitted illegal DME claims worth millions of dollars related to use of telehealth.[16,17] Moreover, reports of providers inflating their time spent in telehealth visits, misrepresenting the services provided, and billing for services not provided have emerged,[18] as have allegations of physicians submitting false claims for opioid and other narcotics prescriptions connected to fraudulent telehealth visits.[15] Program spending associated with telehealth fraud is estimated in the billions of dollars.[15-19]

Next steps

As telehealth has gained widespread acceptance among providers and beneficiaries, especially during the public health emergency, audio-only visits remain a particular concern for policymakers. The Medicare Payment Advisory Commission, which advises the U.S. Congress on matters related to Medicare costs, has recommended making audio-only visits ineligible for payment and reducing payment rates for other telehealth visits due to concerns about services that provide little or no benefit to patients, fraud, and the program resources needed to monitor surging use of telehealth.[20] Even if CMS were to continue authorizing payment for audio-only visits, provider groups have expressed concern about how payers will determine which audio-only services are clinically appropriate and therefore eligible for payment.

Despite these concerns, a growing body of evidence indicates that telehealth has helped maintain or improve access to care among Medicare beneficiaries, and audio-only visits have especially benefited populations facing multiple barriers. Legislation introduced in the 117th U.S. Congress (H.R. 2166 and S.150) would extend the use of audio-only telehealth services specifically for Medicare Advantage enrollees and permit providers to use certain audio-only diagnoses to determine risk adjustment for these enrollees.

Government payers and private insurers have advocated steps—including development of hybrid models that combine in-person visits, audio-video visits, and audio-only visits—to support continued payment for these services. At this writing, CMS is expected to propose at least one hybrid model and payment guidelines for audio-only services,[20] and might address a cascade of program decisions needed to support the ongoing and growing use of telehealth. Such decisions include development of coding and reimbursement rates that pay providers fairly for their time, clear guidance on eligible audio-only versus audio-video telehealth services, and coverage of telecommunication devices as medically necessary equipment.[21]

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