



IDEAS
ACTION
RESULTS

The Future of Telehealth After COVID-19

NEW OPPORTUNITIES AND CHALLENGES

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Bipartisan Policy Center

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HEALTH PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, M.D., BPC's Health Program develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance coverage and delivery. The project focuses on coverage and access to care, delivery system reform, cost containment, chronic and long-term care, rural health, behavioral health, and digital health.

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DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of BPC's founders, its funders, its board of directors, or the members of its Digital Health Advisory Group.

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Glossary of Acronyms

APM	Alternative Payment Model
CBO	Congressional Budget Office
CMMI	Center for Medicare and Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
DME	Durable Medical Equipment
ED	Emergency Department
FWA	Fraud, Waste, and Abuse
FQHC	Federally Qualified Health Center
HHS	U.S. Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
HPSA	Health Professional Shortage Area
MedPAC	Medicare Payment Advisory Commission
MOUD	Medications for Opioid Use Disorder
OCR	Office of Civil Rights
OIG	Office of the Inspector General
PHE	Public Health Emergency
RHC	Rural Health Clinic

Executive Summary

Before COVID-19, Medicare primarily covered telehealth services for beneficiaries living in rural areas, where there were far fewer medical providers, and patients were required to travel to designated sites, such as clinics or hospitals, to receive telehealth. Outside of rural areas, Medicare covered only a limited set of services via telehealth.

Once the pandemic took hold in 2020, Congress and the Trump administration greatly expanded telehealth services for Medicare beneficiaries, keeping their access to care as intact as possible amid stay-at-home orders and public fears about contracting COVID-19.¹ Lawmakers passed legislation to temporarily enable all beneficiaries to access telehealth services from their homes and to allow Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) to act as telehealth providers.

At the same time, U.S. Department of Health and Human Services (HHS) Secretary Alex Azar issued temporary waivers that expanded the types of services that Medicare could provide through telehealth and reimbursed such services at parity with in-person care. All health professionals who were eligible to bill Medicare could now deliver their services via telehealth (including physical therapists, speech language pathologists, and occupational therapists). The secretary also waived Medicare's licensure requirements and allowed providers to use popular technology platforms (e.g., Zoom, FaceTime, Google Meet) for telehealth, despite not being compliant with Health Insurance Portability and Accountability Act (HIPAA) rules for technology use. HHS expanded Medicare coverage for audio-only service (telephone visits without video) and waived the requirement that patients have an established relationship with a provider before receiving telehealth services.

Policymakers, however, tied these flexibilities to the federal COVID-19 Public Health Emergency (PHE). Now, as they contemplate the end of the PHE, they are faced with making decisions that will dictate the future of telehealth. Absent any changes, most Medicare beneficiaries will lose access to telehealth services unless they live in rural areas or enroll in Medicare Advantage.

In this report, the Bipartisan Policy Center releases findings from extensive telehealth research and [Medicare data analysis](#) to inform pragmatic policy decisions that can create a path forward for telehealth policy—policy that will continue to be evidence-based and will promote better outcomes for Medicare beneficiaries and value for the Medicare program.

THE IMPACT OF TELEHEALTH

Dramatic policy changes during the pandemic paved the way for a huge increase in the utilization of telehealth services—from less than 1% of Medicare services before the pandemic to a peak of more than 32% of Medicare claims in April 2020 (leveling off to between 13% and 17% by July 2021).² In the first year of the pandemic, 44% of continuously enrolled Medicare fee-for-service beneficiaries had a telehealth visit, accounting for more than 45 million visits.^{3,4}

The significant expansion of telehealth disproportionately increased access to care in urban communities. In addition, tele-behavioral health services can address problems associated with the paucity of behavioral health providers and help patients overcome the stigma related to these services, especially in more rural, tight-knit communities. In 2021, more than one-third of Americans (37%) lived in areas with shortages of mental health professionals.⁵

Since the onset of COVID-19, HHS's Centers for Medicare and Medicaid Services (CMS) has allowed the use of audio-only services—telehealth without live video. At least 29 state Medicaid programs now reimburse providers for delivering audio-only services.⁶ Older, rural, poorer, and minority populations are disproportionately affected by barriers to accessing telehealth services and have been more likely to rely on audio-only services during the pandemic.⁷ Among telehealth users, Black and Latino patients, along with individuals with lower incomes, had significantly lower access to video services.⁸ However, policymakers, payers, and providers raised concerns that audio-only visits were of lower quality and presented risks of overuse and fraud for the Medicare program.^{9,10}

As for the quality of care, early evidence suggests that services delivered through telehealth can be equivalent to in-person care for managing chronic diseases and treating behavioral health issues. Overall, patients and providers, including those in rural areas as well as Medicare beneficiaries, generally feel satisfied with the telehealth services they receive.^{11,12,13} Nevertheless, virtual care's effectiveness varies depending on the medical condition.

The pandemic-related telehealth flexibilities also created opportunities for fully virtual providers who do not have brick-and-mortar locations to deliver services to Medicare beneficiaries and receive reimbursement. And their presence is growing: 2021 delivered record-breaking venture capital and private equity investments for digital health companies, driven in large part by telehealth investment.¹⁴ These alternative types of providers can expand Medicare beneficiaries' access to services, but some stakeholders expressed concern that this kind of access could further fragment care and compromise patient care.^{15,16}

The pandemic-induced telehealth policy changes also affected costs for the Medicare program as well as beneficiaries. Providers used to be reimbursed for most telehealth services at a lower facility rate—like the reimbursement for providers who deliver care in hospital outpatient departments, rather than the higher rate for office-based services. The rationale for this disparity was that the delivery of telehealth largely resulted in lower practice expenses than in-person care. However, with the onset of the pandemic, Medicare began reimbursing all telehealth services, including audio-only visits, at parity with in-person care, and many state Medicaid agencies and private payers followed suit.

Provider reimbursement rates go a long way toward shaping cost effectiveness. Telehealth is less likely to be cost effective if its services are paid at parity with in-person visits. On the other hand, if payments for telehealth visits are too low, providers could stop delivering these services. Higher reimbursement rates also can result in increases in out-of-pocket spending for beneficiaries. Some stakeholders worry that individually paying for virtual interactions (e.g. phone calls, portal messages) using a fee-for-service model makes it less likely the technology will be cost-effective; value-based payment models may be better suited to reimburse virtual interactions, especially since health systems during the pandemic are seeing steady increases in the use of secure email and phone calls as a percent of total outpatient visits.^{17,18}

One question is the degree to which access to telehealth services substitutes for in-person care. That is, do patients have both telehealth and in-person visits for the same complaint, increasing the overall volume of health services, or do they simply replace their in-person visit with a telehealth visit? Because of telehealth's ability to make care more accessible, the Congressional Budget Office (CBO) has historically projected that expansions in telehealth will increase health care spending; however, an individual's clinical condition as well as how virtual care is being used by a provider are both key factors in determining the balance of substitutive versus additive care.¹⁹

BPC'S RESPONSE

The temporary policy changes to expand telehealth, and the increased utilization that resulted, raise a series of questions about whether policymakers should make these changes permanent. What types of services should remain accessible via telehealth beyond the PHE? Under what circumstances? And how should reimbursement work?

The Bipartisan Policy Center began an extensive effort in April 2021 to develop evidence-based federal policy for the effective use of telehealth beyond the PHE. To study the issue and develop recommendations, BPC pursued a multipronged approach that included:

- A targeted literature review of more than 200 documents, including peer-reviewed articles and published government and industry reports;
- A Medicare fee-for-service [analysis](#) of telehealth utilization data before and during the pandemic;
- Almost two dozen in-depth stakeholder interviews with providers, provider associations, payers, federal agencies, technology leaders, consumer advocates, and policy experts;
- A national consumer survey on telehealth usage; and
- An expert digital health advisory group to help inform policy recommendations.

BPC assessed telehealth’s impact on patient access to care and analyzed quality, outcomes, and cost. We also balanced often competing goals to develop recommendations for the Medicare program. For example, valuing beneficiaries’ access to care can directly affect overall utilization; conversely, maintaining a high bar on quality care can present barriers to broadly expanding access.

BPC’S FINDINGS

Policymakers and health care experts emphasize the need to systematically examine the impact of telehealth utilization in normal—that is, non-PHE—times. More research will help providers and policymakers identify which telehealth interventions provide positive health benefits for patients, versus those which have little-to-no clinical value. Nevertheless, the dramatic increase in telehealth usage during the pandemic has proved instructive, and policymakers should draw lessons and take certain steps based on that experience.

For starters, Congress and the Biden administration should extend most of the telehealth flexibilities for Medicare beneficiaries for two years after the end of the PHE, and formally evaluate their impact. Researchers should evaluate the benefits of hybrid (in-person and virtual) care models for primary and specialty care, including for which conditions and specialties it is most effective, further evaluate full telehealth flexibilities in the context of value-based payment models, and rigorously assess the quality of audio-only care.

Throughout this report, BPC recommends targeted adjustments to the current telehealth flexibilities; all recommended changes are in response to emerging evidence on benefits versus risks and to stakeholder concerns. This approach would enable beneficiaries to maintain their access to telehealth services while minimizing risks to patients and the Medicare program, as well as provide time for policymakers to continue to review and assess the evidence.

BPC believes the administration and Congress should maintain access to telehealth for Medicare beneficiaries regardless of their location or medical diagnosis. This will ensure that equitable access to health care continues across

populations with different conditions. Telehealth policies should also include strong protections to ensure that beneficiaries understand their telehealth benefits, that they are protected against misuse that could undermine the quality of their care, and that their health information is private and secure. This protection includes requiring providers to see patients in-person or having the ability to send patients to in-person care when necessary.

Providers participating in value-based payment models have the financial incentive to use telehealth only when it is cost effective; as a result, they are incentivized to adopt higher-value uses of telehealth in their practices. Providers in Alternative Payment Models (APMs) with two-sided risk should have maximum flexibility to use telehealth with their patients—including the flexibility to use audio-only visits and establish virtual-first relationships with specialists. Medicare already allows flexibility for providers participating in APMs to bill for telehealth services, and the Center for Medicare and Medicaid Innovation (CMMI) should allow current telehealth flexibilities in all new models where providers are participating in two-sided risk.

After the onset of COVID-19, telehealth was essential in maintaining beneficiaries' access to services. Importantly, primary care composed about 39% of telehealth visits in the first three quarters of 2021, while primary and behavioral health care combined made up about two-thirds of telehealth visits for the [study](#) population during that period.²⁰ BPC recommends that telehealth access to primary care and behavioral health services continue with minor adjustments post-PHE. While tele-behavioral health access is permanently authorized beyond the PHE, tele-primary care is not and will end with the current temporary flexibilities. Additionally, if further evaluation supports it, CMS could consider limiting other tele-specialty care to existing patient-provider relationships, except for rural areas and providers participating in APMs.

The pandemic underscored the critical importance of internet connectivity for people needing to access work, school, or health care, among other things. People who live in rural or frontier communities without sufficient broadband, or who cannot afford or use the technology needed for video visits, should continue to have access to audio-only services; however, this access comes with new risks to quality and costs.

In 2021, almost 1 in 5 telehealth services were delivered to Medicare beneficiaries via telephone, and this figure was likely an underestimate because of provider miscoding.^{21,22} BPC interviewed several primary care providers serving predominately vulnerable populations who expressed concern with the quality and efficacy of audio-only visits for new patients. Once the PHE ends, policymakers should place new restrictions on audio-only services, including requiring that providers should deliver care only over the phone for patients with whom they have an existing treatment relationship. The decision for a phone visit should be patient-directed, not the result of a provider limitation.

The Consolidated Appropriations Act of 2021 made access to telemental health services for Medicare beneficiaries permanent. However, the legislation also included a provision that required beneficiaries to see their provider in-person at least six months before accessing the telehealth benefit. There is much evidence to support the effectiveness of telemental health services. Congress should eliminate the requirement for in-person visits for telemental health services, which creates an undue burden on those who cannot access behavioral health providers in-person.

Finally, Medicare should leverage its current process to refine reimbursement rates for telehealth after the PHE to better reflect the effort and expenses for the type of care delivered. The more Medicare pays, the higher the beneficiary out-of-pocket spending for telehealth services. Policymakers should end broad payment parity between telehealth and in-person care, which may help retain telehealth providers participating in Medicare, but which also may overpay such providers relative to their costs.

BPC makes the following recommendations:

RECOMMENDATIONS

Section I: Foundational

Ensure Equitable Access to Care

- Congress should amend Section 1834(m) of the Social Security Act to permanently remove geographic restrictions for telehealth and to include the home of an individual, or wherever the patient is located, in the list of authorized originating sites.
- Congress should permanently authorize FQHCs and RHCs to serve as distant sites by amending Section 1834(m) of the Social Security Act.
- Congress should incorporate audio-only telehealth services into the definition of telehealth. Beyond that, the secretary of HHS should limit audio-only services to beneficiaries with established patient-provider relationships.
- Congress should make HHS's 1135 temporary waiver authority permanent for future public health emergencies as well as extend HHS's current authorities for two years post PHE.

Ensure Benefit Transparency and Consumer Protections for Telehealth Services

- CMS should ensure telehealth benefits are clearly communicated to beneficiaries, including services appropriate to be delivered via telehealth, and consented to by the beneficiary. Audio-only visits should always be patient-initiated.

- CMS should require providers delivering telehealth services to have the capacity to deliver services in-person, or else ensure that beneficiaries have the option to schedule in-person visits with local providers within a reasonable timeframe.
- CMS should distinguish between traditional and fully virtual providers in Medicare, either via a new modifier, provider category or another approach determined appropriate by the secretary, to evaluate cost and quality outcomes of these providers.
- HHS's Office of Civil Rights (OCR) should resume enforcement of penalties on providers for noncompliance with HIPAA rules for technology use. OCR has already informed providers that oversight will resume at the end of the PHE.
- HHS's Office of the Inspector General (OIG) should resume enforcement of cost-sharing expectations for beneficiaries' telehealth and audio-only visits, which OIG halted during the pandemic, and inform providers and beneficiaries that this oversight will resume.
- CMS should monitor the appropriate use of virtual check-ins versus telehealth appointments and consider aligning current reimbursement policy regarding virtual check-ins with telehealth services.

Strengthen Fraud, Waste, and Abuse (FWA) Protections

- Congress should ensure OIG and CMS have sufficient funding to modernize capabilities and proactively track FWA for telehealth and audio-only services.
- CMS should require audits of outlier providers who are delivering a high volume of high-cost durable medical equipment (DME) and high-cost laboratory tests via telehealth or for other services determined by the secretary to be prone to fraud, waste, or abuse.
- CMS should require all high-cost DME and high-cost laboratory tests be ordered in the context of established patient-provider relationships, except for providers participating in APMs with two-sided risk.

Incentivize Provider Participation in Value-Based Care

- CMS should permanently maintain all telehealth and audio-only flexibilities for providers participating in APMs with two-sided risk arrangements, including using audio-only visits and establishing virtual-first relationships with specialists.

Improve Data Quality for Future Policymaking

- CMS should develop additional guidance for the billing of telehealth and audio-only services to ensure appropriate coding, billing uniformity, and improved data quality.
- CMS should assign a medical specialty to advanced-practice nurses and physician assistants to appropriately differentiate primary and specialty care.

- CMS should prohibit “incident to” billing by any provider who can bill Medicare directly.

Right-Size Reimbursement for Telehealth Services Post-PHE

- CMS should leverage its current process to determine appropriate reimbursement for video-based telehealth and audio-only services. Post-PHE, telehealth visits will likely be paid as a fraction of in-person visits. CMS should also implement a differential payment between audio-only and video visits.

Section II: Behavioral Health

Refine Existing In-Person Visit and Established Patient Requirements

- Congress should repeal in-person visit requirements for telemental health services.
- CMS should implement established patient requirements for audio-only behavioral health services. Beneficiaries should be allowed to establish a patient-provider relationship via video for behavioral health services.

Continue to Evaluate Controlled Substance Prescribing

- For non-hospice, non-cancer patients, CMS should require an in-person examination by the prescriber or a colleague in the same practice for the specific issue before prescribing opiate pain medications or other substances determined by the secretary to be prone to abuse.
- Congress should require HHS to complete a formal evaluation of controlled substance prescribing behavior via telehealth, including medications for opioid use disorder (MOUD).

Section III: Primary Care

Extend Access to Tele-Primary Care Services for Two Years Post-PHE

- Congress should grant waiver authority to HHS to extend access to tele-primary care services for Medicare beneficiaries for two years after the end of the PHE and require the Medicare Payment Advisory Commission (MedPAC) to complete a formal evaluation of the effect on access, quality, patient outcomes, and cost.

Refine Access to Audio-Only Tele-Primary Care Services

- CMS should implement established patient requirements for tele-primary care audio-only services.

Evaluate Reimbursement for Tele-Primary Care Services Post-PHE and Test New Payment Models

- CMS should continue to evaluate whether telehealth reimbursement for FQHCs and RHCs is adequate to ensure they continue to use telehealth in a way that best serves vulnerable populations.
- CMMI should use lessons learned from current Medicare demonstrations to inform new models that incorporate virtual care services.

Section IV: Other Specialty Services

Refine Access to Other Tele-Specialty Services

- Congress should grant waiver authority to HHS to extend access for tele-specialty services to Medicare beneficiaries for two years after the end of the PHE and require MedPAC to complete a formal evaluation of the effect on access, quality, patient outcomes, and cost.
- Congress should allow newly eligible health care professionals, such as physical therapists, occupational therapists, speech-language pathologists, and audiologists, to continue to bill for telehealth services during the two-year extension period, and HHS should evaluate the cost and quality outcomes of their services before allowing them to bill Medicare directly on a permanent basis.
- If further evaluation supports it, CMS should consider implementing established patient requirements for other tele-specialty care, except for beneficiaries living in rural and frontier areas, and for providers participating in APMs with two-sided risk.
- CMS should limit audio-only visits for specialty services to rural and frontier areas, non-rural beneficiaries with attested access barriers to video visits, and for providers participating in APMs with two-sided risk.
- CMS should permanently expand asynchronous (store-and-forward) services beyond virtual check-ins, and Alaska and Hawaii demonstrations for Medicare beneficiaries.

Introduction

During the COVID-19 federal public health emergency, Congress and HHS temporarily expanded coverage of telehealth, giving providers broad flexibility to deliver health care services via two-way video or by telephone. Hospitals, physicians, and other providers responded by rapidly adopting telehealth to provide continued access to medical care for their patients, ensuring their reduced exposure to COVID-19.

Many of the telehealth flexibilities are temporary and linked to the federal PHE, which began January 27, 2020.²³ The Biden administration has thus far renewed the PHE through October 15, 2022, and it might extend it again through January 2023. The Consolidated Appropriations Act of 2022 ([P.L.117-103](#)) extended several telehealth provisions for an additional 151 days (approximately five months) beyond the end of the PHE.²⁴

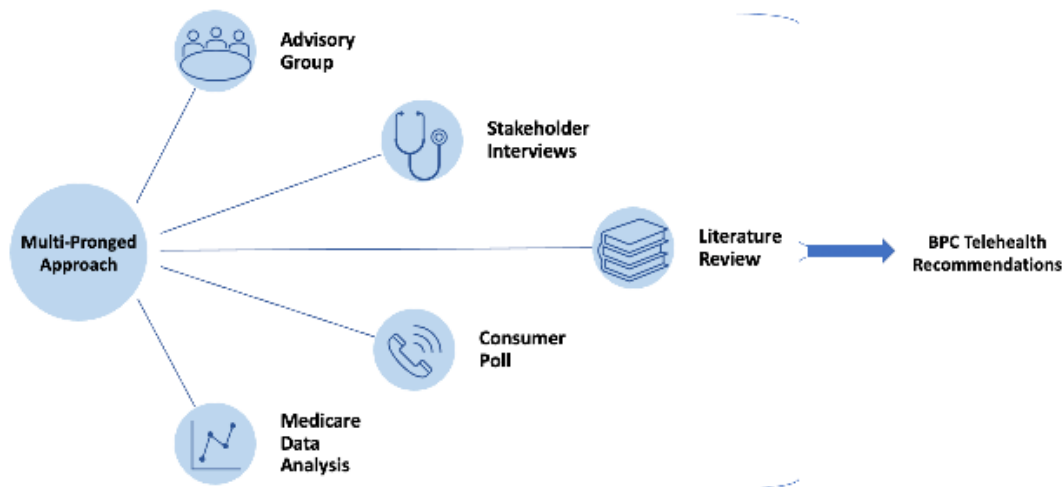
The extension, however, gives policymakers limited runway post-PHE to determine Medicare beneficiaries' long-term access to telehealth services. Unless Congress acts, pre-pandemic telehealth restrictions will be reinstated, and Medicare beneficiaries could face a sudden loss of access to most virtual care services—a phenomenon often referred to as the telehealth cliff.

Additionally, continued uncertainty over permanent telehealth coverage, as well as disparate federal and state policies, harm telehealth's long-term sustainability, as more providers may opt to proceed with caution. Providers will only undertake the investment in video-based telehealth technology and the necessary staff training if they believe they will be able to recoup that investment over time.

Against this backdrop, the Bipartisan Policy Center undertook an extensive effort in April 2021 to develop evidence-based federal policy for the effective use of telehealth services beyond the public health crisis brought on by COVID-19. BPC developed a multipronged approach (see Figure 1), which included:

- A targeted literature review assessing more than 200 documents, including peer-reviewed articles and published government and industry reports;
- A Medicare fee-for-service [analysis](#) of telehealth utilization data before and during the COVID-19 pandemic;
- Almost two dozen in-depth stakeholder interviews with providers, provider associations, payers, federal agencies, technology leaders, consumer advocates, and policy experts;
- A [national consumer experience survey](#) on telehealth use; and
- The creation of an expert digital health advisory group to provide guidance on policy recommendations.

Figure 1: BPC's Evidence-Based Policy Approach



Evaluations of telehealth's impact on equitable access to care and on quality, cost, and patient outcomes will continue to inform federal telehealth policy in the years to come. Congress recently required the compiling of several reports, to be delivered by June 15, 2023, evaluating telehealth flexibilities.²⁵ First, MedPAC, an independent congressional agency that advises Congress on Medicare payment policy, must conduct a study on the expansion of telehealth services, including the effects on utilization, expenditures, quality, and access to care. Second, OIG must evaluate program integrity risks associated with Medicare telehealth services. Finally, the HHS secretary must make Medicare telehealth claims data publicly available on a quarterly basis beginning July 1, 2022, including data on utilization and beneficiary characteristics.

BPC's current work examines the evidence to date and offers recommendations for permanent telehealth policy changes where the evidence exists, as well as recommendations for areas of continued flexibility and analysis. This report is divided into five areas:

- An **overview of the current evidence** regarding telehealth's impact on equitable access to care and on quality of care, patient outcomes, and cost
- Recommendations for broad, **foundational telehealth policies** that affect access to telehealth services across the health care delivery system
- A review of the current **mental health and substance use service** flexibilities and recommendations for further refinement
- An assessment of the critical importance of **tele-primary care** services during the pandemic and recommendations for continued flexibility
- A summary of **tele-specialty care** during the pandemic and recommendations for new guardrails beyond the PHE

It is important to note that throughout our interviews, stakeholders highlighted significant concerns regarding the effects of interstate licensure and broadband access for rural and frontier areas on telehealth's future. BPC has released several reports over the past year that include recommendations on these key topics. In November 2021, BPC released [*What Eliminating Barriers to Interstate Telehealth Taught Us During the Pandemic*](#), which provided options to the Medicare program to further accelerate the recognition of provider licenses across states. In April 2022, BPC released [*The Impact of COVID-19 on the Rural Health Landscape*](#), which described the challenges surrounding rural health care access and care delivery during the pandemic and highlighted, among other things, recommendations regarding the equitable expansion of broadband. As a result, licensure and broadband expansion recommendations are not included as part of this report.

BPC urges Congress and the secretary of HHS to extend the existing telehealth flexibilities for Medicare beneficiaries for two years after the end of the PHE, with a few exceptions, while further evaluating their impact. We believe the approach outlined in this report would enable beneficiaries to maintain access to telehealth services while minimizing risks to patients and the Medicare program and allow sufficient time post-PHE to assess effectiveness.



Telehealth Landscape

Since the beginning of the COVID-19 pandemic in 2020, temporary telehealth flexibilities greatly expanded the coverage of virtual services for Medicare beneficiaries – for the first time they were allowed to receive care virtually no matter where they lived in the United States.

The unprecedented expansion of telehealth was meant to retain people’s access to services, to the extent possible, as in-person care plummeted because of stay-at-home orders and public fear about contracting the virus. This dramatic policy shift generated a series of policy questions about whether certain flexibilities should remain permanently available to beneficiaries. These questions included what types of services should remain accessible via telehealth and the specific circumstances or clinical areas where patients would benefit from access to telehealth, by what modality, and how beneficiaries’ care should be reimbursed.

MedPAC and other experts have said that permanent telehealth policy changes are ill-advised until more research is undertaken on telehealth’s effectiveness and costs. Policymakers have also expressed concerns that telehealth could be overused without appropriate oversight and could result in lower quality care for Medicare beneficiaries. Additionally, overuse and abuse of telehealth services could unnecessarily increase government expenditures on Medicare.

Over the past year and a half, BPC performed an evidence-based evaluation of telehealth’s impact on equitable access to care and on quality of care, patient outcomes, and cost. The work contained in this report synthesizes findings

from across the available published literature, an independent Medicare data analysis, and in-depth interviews with stakeholders and digital health experts, as well as a national consumer experience survey on telehealth use.

BPC contracted with Ananya Health Solutions to conduct a longitudinal, descriptive analysis of telehealth utilization and spending for Medicare fee-for-service beneficiaries across 2019, 2020, and the first three quarters of 2021. The analysis focused on outpatient visits that could be delivered via telehealth across behavioral health, primary care, and specialty care, and it characterized telehealth utilization by beneficiary and other characteristics. The study also included an analysis of potential spending effects on the Medicare program associated with extending certain telehealth flexibilities once the PHE ends. For the complete methodology and findings of BPC’s Medicare data analysis, see [Medicare Telehealth Utilization and Spending Impacts 2019-2021](#).

The following section summarizes permanent, as well as pandemic-related, telehealth policies, and synthesizes myriad evidence on telehealth’s impact on access to care, quality, clinical outcomes, and cost. It is important to note, however, that telehealth is an area of active research and evidence continues to evolve. For example, the Patient-Centered Outcomes Research Institute (PCORI) made up to \$50 million available last month to fund studies to determine the comparative clinical effectiveness of different approaches to telehealth to best treat patients with multiple chronic conditions.²⁶

It is also important to acknowledge that while the findings below are categorized by telehealth’s impact on access and on quality, patient outcomes, and cost, the evidence across these outcomes and associated trade-offs has been considered for the development of BPC’s recommendations. For example, BPC in places recommends policies that value access to care over expected increases in utilization, but in other instances the importance of maintaining quality care outweighs the importance of broad access. In addition, we cite examples where costs to the Medicare program overshadow the benefits of continuing certain telehealth flexibilities beyond the PHE.

PERMANENT TELEHEALTH POLICY

Before the COVID-19 pandemic, telehealth services were mostly authorized on a permanent basis for those living in rural areas. Patients were also, for the most part, required to receive telehealth services at an “originating site”—meaning they had to travel to a provider’s office or local hospital to receive their virtual care. Treating providers delivering care from a “distant site” were reimbursed for their services. Originating site providers were reimbursed separately for hosting the interaction.

Since 2003, CMS has leveraged a regulatory process to evaluate telehealth benefits and determine coverage of telehealth services for Medicare beneficiaries. CMS provides the public with the opportunity to submit requests

to add or delete telehealth services and coverage, and payment decisions are communicated annually through CMS's Physician Fee Schedule rule.²⁷ Services can be added to the coverage list if they resemble a service already on the permanent telehealth services list (Category 1), or if there is sufficient evidence to show that the service can be safely and effectively provided via telehealth (Category 2). In 2020, CMS added a third category (Category 3) as a temporary holding place for some of the telehealth services that had been added during the pandemic. CMS felt more time was needed to gather evidence for telehealth services identified as having a reasonable likelihood of clinical benefit. Category 3 services will remain available until the end of 2023. Before the PHE, CMS approved 118 services that could be delivered via telehealth; this increased to 264 services during the pandemic.²⁸

Telehealth services were authorized beyond rural areas before the pandemic for a limited set of services, including stroke care, home dialysis, substance use disorder, and mental health treatment.

Telestroke qualified for Medicare reimbursement outside of rural areas through the Furthering Access to Stroke Telemedicine (FAST) Act, which passed as part of the Bipartisan Budget Act of 2018 ([P.L.115-123](#)) and went into effect on January 1, 2019.^{29,30} Strong evidence supports the use of telestroke, especially because the therapeutic window to treat stroke is so short and neurologists are in short supply in rural and many other communities.^{31,32,33} The Bipartisan Budget Act also allowed patients on home dialysis to choose to have their monthly clinical assessments via telehealth.

The SUPPORT for Patients and Communities Act ([P.L. 115-271](#)) exempted substance use disorder and co-occurring mental health disorders from specific telehealth requirements under Medicare, such as geographic and site of service restrictions.³⁴ The SUPPORT Act, which took effect on July 1, 2019, allowed eligible Medicare beneficiaries to begin receiving substance use disorder treatment services in the home via telehealth.³⁵

The last major extension of permanent telehealth flexibilities was for telemental health services with passage of the Consolidated Appropriations Act of 2021 ([P.L.116-260](#)).³⁶ Telemental health has a robust evidence base—numerous studies have documented its effectiveness and comparability to in-person care. It allowed Medicare beneficiaries, beyond those in rural areas, to receive mental health treatment via telehealth after the COVID-19 emergency period ends. Congress included a requirement that patients be seen by their provider in-person before and while accessing telemental health services.

Additionally, in 2019, Medicare began paying for virtual check-ins for all established patients (not just rural). These are brief, five- to 10-minute, patient-initiated phone calls or video chats to see whether patients need to make an office visit. Patients must verbally consent to virtual check-ins and they can be initiated via a portal message or email to a provider; to be reimbursed, the

visits cannot relate to a prior visit within the past seven days with the same provider or lead to another visit within the next 24 hours, or soonest available appointment.³⁷ Virtual check-ins can also allow providers to review recorded video or images from established patients, and they can follow-up with the patient within 24 hours.

COVID-19 PHE-RELATED TELEHEALTH FLEXIBILITIES

Congress acted quickly after the onset of the pandemic to expand access to telehealth services through the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 ([P.L.116-123](#)) and the Coronavirus Aid, Relief, and Economic Security Act of 2020 (also known as the CARES Act) ([P.L. 116-136](#)).^{38,39}

The CARES Act temporarily waived requirements for distant site providers, allowing FQHCs and RHCs to act as treating providers. Before the pandemic, FQHCs and RHCs were only considered originating site providers for telehealth, meaning they could host patients who were receiving telehealth services onsite from other providers, but they were not able to act as treating (distant site) providers.

The secretary of HHS issued temporary blanket waivers, based on new waiver authority included in the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020.⁴⁰ Temporary changes to telehealth policy included:

- Lifting geographic and site of service requirements, which allowed all beneficiaries, regardless of medical condition, to access telehealth services from their homes.
- The addition of 146 new telehealth codes to the list of Medicare approved telehealth services.
- Reimbursement of all telehealth visits at parity with in-person services.
- Allowing all health professionals eligible to bill Medicare to deliver telehealth services (e.g., social workers, physical therapists, speech language pathologists, occupational therapists)
- Providing flexibility for health care providers to reduce or waive beneficiary cost-sharing requirements.
- Waiving Medicare licensure requirements, secondary to the state licensure laws.
- Implementing HIPAA enforcement flexibility to permit providers to use any common non-HIPAA compliant technology platform (e.g., Zoom, FaceTime, Google Meet) for telehealth services.

- Expansion of audio-only (telephone) visits for certain services, such as office visits and behavioral health services.
- Waiving audits to ensure the patient had an established relationship with a provider before receiving telehealth services.

Dramatic changes to telehealth policy during the pandemic paved the way for an unprecedented utilization of telehealth services. Telehealth accounted for less than 1% of outpatient services before the pandemic; by April 2020, telehealth claims peaked at more than 32% of Medicare claims before leveling off to between 13% and 17% by July 2021.⁴¹

Fully virtual telehealth providers did not bill traditional Medicare fee-for-service before the PHE because a patient's home was not considered an originating site. However, with the new pandemic-related telehealth flexibilities, fully-virtual, providers were able to begin billing Medicare directly. Importantly, it is currently not possible when using Medicare claims data to distinguish between fully virtual providers and brick-and-mortar providers who deliver telehealth services.⁴² Stakeholders have raised the question whether the former should be identified through a new modifier or as a new provider type to be able to assess their quality.

ACCESS TO CARE

With the new flexibilities brought on by the pandemic, a broad swath of providers in rural and urban areas adopted telehealth technologies, creating many new access points to care for Medicare beneficiaries.^{43,44} Before the pandemic, telehealth sought to expand health care access in rural settings by linking patients to providers in urban hubs. However, its use during the pandemic demonstrated that telehealth has the potential to improve access to care in both rural and urban settings.

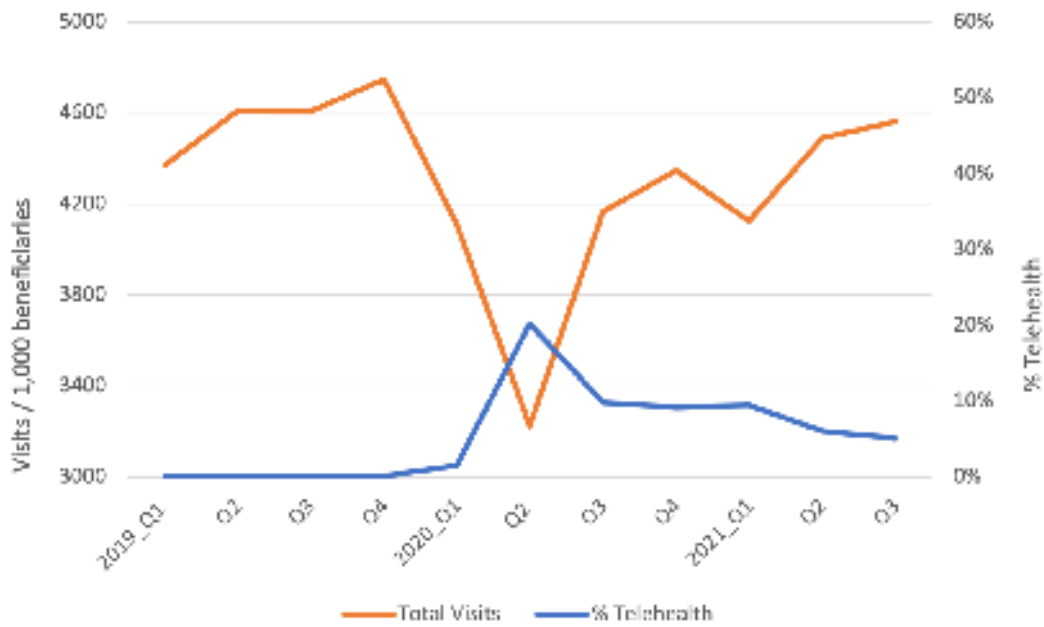
Indeed, urban and suburban areas [saw](#) higher telehealth visits per 1,000 people compared with telehealth visit rates in non-metro areas in 2020 and 2021.⁴⁵ The digital divide—the gap between populations who have access to modern information and communication technologies and those who do not—may be contributing to higher telehealth uptake in urban areas, although broadband challenges exist in urban areas as well. However, researchers have also found that rural residents may value in-person connection and care rooted in the community more than their urban counterparts—leading to a preference for in-person care when it is available.⁴⁶

Despite declines in telehealth utilization in 2021, its use still far exceeded pre-pandemic levels. In the first year of the pandemic, 44% of continuously enrolled Medicare fee-for-service beneficiaries had a telehealth visit, [accounting](#) for more than 45 million visits.⁴⁷ Although this number declined in the first three quarters of 2021, 28% of beneficiaries still had at least one telehealth visit

(see Figure 2).⁴⁸ Telehealth utilization remained high in comparison to 2019 when less than 1% of beneficiaries had a telehealth visit. Analyses have found that the monthly volume of evaluation and management telehealth services plateaued between 8.5% and 9.5% of visits by the fourth quarter of 2021.⁴⁹ These data show that a significant proportion of beneficiaries continue to rely on telehealth services to access care.

Figure 2: Medicare Beneficiaries’ Total Outpatient Visits and Percent Telehealth, 2019-2021⁵⁰

Telehealth utilization peaked in the second quarter of 2020 and remains higher than pre-pandemic levels, although total visit rates were lower in 2020 than in 2019.



	2019	2020	2021 Q1-Q3
Medicare FFS beneficiaries in study population	30,339,433	29,550,125	28,212,465
Telehealth users*	205,914	12,988,415	7,931,506
Telehealth users as a percent of study population	1%	44%	28%
Total telehealth visits	645,195	45,035,087	25,249,283
Telehealth visits as a percent of total visits	0.12%	9.61%	6.79%

*Medicare FFS beneficiaries who had at least one 1 telehealth (and/or audio-only) visit during the study period

The last two years highlighted the ways telehealth can help patients overcome obstacles to getting care. Travel times, provider availability, and inability to miss workdays are often barriers to getting needed health care.⁵¹ Access to telehealth can help alleviate some of these barriers for Medicare beneficiaries. For example, one Ohio medical system found that their patients traveled 12.2 million fewer miles from March 2020 to July 2020 due to telehealth

availability.⁵² Black patients were more likely to complete follow-up visits after their discharge from the hospital when they had access to telehealth; completion rates for these patients increased by 18 percentage points between January 2020 and June 2020.⁵³ In addition, many studies have shown that patients miss fewer telehealth appointments and have significantly fewer cancellations across service types.^{54, 55, 56, 57, 58} As a result, telehealth has the potential to improve patient continuity of care by increasing the likelihood that they will continue to see their provider and attend scheduled appointments.⁵⁹

Telehealth may help address inequities in health care access and outcomes. Evidence demonstrates that racial and ethnic minorities, low-income earners, and individuals with chronic conditions face difficulties accessing care, regardless of where they live.⁶⁰ These impediments can include appointment availability, mobility issues, an inability to miss work, or to secure transportation. The COVID-19 pandemic highlighted both gaps in access to care and disparities in outcomes. For example, minority populations have experienced higher COVID-19 mortality rates than have white populations.

Telehealth may increase access to care for communities of color and other marginalized groups. Although not all studies have found disparities in telehealth utilization by race and ethnicity, many have. According to [CMS data](#), 58% of Black beneficiaries and 64% of Hispanic beneficiaries had a telehealth visit between March 1, 2020, and February 28, 2021, compared with 51% of white beneficiaries.⁶¹ Notably, [survey data](#) from the Pew Research Center found that Black respondents were most likely to report using telehealth during the pandemic. Patients living in the most disadvantaged neighborhoods were also more likely to utilize telehealth after Medicare coverage waivers were enacted.⁶² These data indicate that leveraging telehealth to deliver appropriate care has the potential to reduce health care disparities. BPC's [Medicare data analysis](#) also found that telehealth visit rates for American Indian/Alaska Native, Black/African American, and Hispanic groups exceeded the overall telehealth visit rates per 1,000 beneficiaries at the national level.⁶³ However, some researchers note that it is difficult to ascertain whether differences in telehealth utilization by sociodemographic characteristics are a reflection of digital access barriers or pandemic-related shelter-in-place orders and physical distancing preferences.⁶⁴

Providing access to behavioral health services can also have an impact on health equity for populations with limited access to these providers. Often characterized as the “second pandemic,” COVID-19 exacerbated and fueled a mental health crisis in the United States. Approximately 4 in 10 adults reported symptoms of anxiety and depression in January 2021—nearly four times as many as before the pandemic started, while more than a quarter of young adults and 22% of essential workers reported suicidal thoughts.⁶⁵

Access to tele-behavioral health services can address problems associated with the paucity of behavioral health providers and help patients overcome the

stigma related with these services, especially in rural, tight knit communities. In 2021, more than one-third of Americans (37%) were living in areas experiencing shortages of mental health professionals.⁶⁶ Without access to telehealth, many beneficiaries may lack the ability to see a behavioral health provider. Compared to other telehealth services, tele-behavioral health utilization did not see significant reductions in 2021. Notably, tele-behavioral health visits [accounted](#) for between 40% and 50% of behavioral health visits in 2021.⁶⁷

Since the pandemic's onset, CMS has reimbursed for audio-only services, which are telehealth services without live video, allowing beneficiaries with technology-related barriers to access care. Payment was limited for audio-only visits across payers before the pandemic, but coverage of these visits was one of the most common COVID-19 temporary telehealth policy expansions. At least 29 state Medicaid programs now reimburse the modality permanently in some way (e.g., sometimes only for mental health or case management).⁶⁸ A [RAND analysis](#) of health centers in California found that although audio-only visits were the leading telehealth modality for primary care and behavioral health services throughout the pandemic, in-person visits were more common than audio-only visits for primary care.⁶⁹ In other words, vulnerable populations who seek care at health centers may be more likely to rely on audio-only services, but they still tend to use in-person care, rather than telehealth, for certain services.

Older, rural, poorer, and minority populations have been more likely to rely on audio-only services during the pandemic because they are disproportionately affected by barriers to telehealth services.⁷⁰ Additionally, there is evidence that network providers underinvest in lower-income communities (often communities of color), excluding them from broadband service—a practice known as digital redlining.⁷¹ Studies show that among telehealth users, Black and Latino patients, along with those with lower incomes, had significantly diminished access to video services.⁷² Moreover, patients with limited English proficiency were less likely to participate in video visits—potentially pointing to digital literacy issues or a cultural preference for in-person care.⁷³

Stakeholders noted that access to audio-only services was critical for residents without broadband and for patients who had difficulty accessing and using video. Some stakeholders indicated that community mental health centers in rural areas advocate for the continued use of audio-only services, given technical barriers to video and in-person services. However, providers have raised concerns about the limitations of audio-only visits that occur outside of an existing patient-provider relationship.

Although the administration has allowed permanent coverage for audio-only services when it is used to provide behavioral health services, the use of this modality for other health care services is still being debated. Recognizing that access to audio-only services could help alleviate health inequities, policymakers will have to balance access for patients who may not have other

options with the potential to create a two-tiered system where some have access to higher quality, face-to-face interventions and others can only access health care via audio.⁷⁴

QUALITY OF CARE AND PATIENT OUTCOMES

Early evidence suggests that services delivered via telehealth are largely equivalent to in-person care for the management of chronic diseases, behavioral health, and video-based physical therapy and rehabilitation, although variations do exist.^{75,76,77} Limited and mixed evidence points to the need for additional analyses on clinical outcomes, especially in the years following the PHE. Future policy will need to rely on specific studies that can generate rigorous evidence of telehealth's impact on clinical quality and outcomes related to services and conditions.

Behavioral Health

Studies evaluating tele-behavioral health versus in-person care generally showed that the two modalities produced similar outcomes for certain conditions. Meta-analyses found that telehealth produced equivalent outcomes (symptom reduction) compared with in-person care (for PTSD, ADHD, major depressive disorder, and autism), although there were variations in outcomes related to psychiatric conditions. For example, PTSD treatment administered via video did not result in significantly different symptom severity in the short-term compared with in-person care, but worse outcomes were reported at three-to-six-month follow-ups compared with in-person care. The opposite was true for depressive symptoms.⁷⁸ Virtual consultations for psychiatric conditions delivered to nursing home residents showed that consultations were comparable to in-person assessments.⁷⁹

Evidence suggests that receiving behavioral health services via audio-only does not diminish quality of the patient-provider interactions. Studies comparing in-person and video services to audio-only services for behavioral health revealed evidence that the modes produced few differences in terms of therapeutic alliance, disclosure, empathy, attentiveness, or participation. However, although audio-only therapy sessions produced similar outcomes, they were significantly shorter than those conducted face-to-face. Nearly half (47%) of audio-only sessions were less than 30 minutes, compared with 7.4% of face-to-face sessions.⁸⁰

Research specific to substance use disorder (SUD) and telehealth utilization has continued to increase during the pandemic. A 2022 study looking at FQHC patients found that telehealth flexibilities were effective in retaining patient access to MOUD and that the patients were able to transition to telehealth without any obstacles.⁸¹ A rapid review of evidence from 17 randomized

controlled trials found uncertain evidence that telehealth is similar to in-person care for SUD outcomes—but limited evidence suggested some added benefit of incorporating telehealth visits with usual substance use care.⁸² A review by HHS’s Substance Abuse and Mental Health Services Administration (SAMHSA) found strong evidence to support medication-assisted treatment for opioid use disorder using a hybrid telehealth and in-person approach.⁸³

Primary Care

Studies evaluating the effectiveness of tele-primary care services have produced mixed results. Overall, patients and providers are overwhelmingly satisfied with tele-primary care. However, quality of care across conditions, such as chronic disease and infection management, was inconsistent. In the primary care setting, online health exams, in combination with other virtual tools, improved the effectiveness of primary prevention by motivating patients to change unhealthy behaviors compared with standard in-person care.⁸⁴ Studies included a variety of interventions, making it more difficult to ascertain the value of online health exams alone.

One study found that tele-primary care was associated with increased use of acute care visits, including emergency department (ED) visits and hospitalizations. This could indicate that telehealth may not substitute for in-person services. However, researchers noted that these findings may be due to deferred or reduced access to routine care during the pandemic—worsening acuity.⁸⁵

The impact on quality of care varied across conditions, with quality defined differently across studies. Most studies considered only clinical outcomes (including quality of life) and patient satisfaction as measures of quality. One study found that telehealth was more effective than the usual, in-person care at controlling glycemic index for diabetes patients but was similar to in-person care for controlling body mass index and total cholesterol.⁸⁶ Studies evaluating telehealth use for wound care and infectious diseases produced inconsistent findings, but showed that telehealth generally led to positive outcomes for healing and fewer amputations.⁸⁷ One study conducted on patients with cold symptoms evaluated whether providers adhered to standards based on specialty societies’ lists of recommendations of tests and treatments that may be unnecessary. Researchers found no significant differences in guideline adherence for antibiotic prescribing for sinusitis between telehealth and in-person visits.⁸⁸

Specialty Services

The evidence for clinical outcomes associated with specialty services provided via telehealth varied based on condition and provider type. Although studies evaluating a variety of specialties and diagnoses will shape future policy, the volume of studies assessing physical therapy and cardiology services delivered via telehealth was the highest. A BPC [analysis](#) of Medicare data found that after

primary care and behavioral health, telehealth visits for cardiology services were the largest in order of magnitude.⁸⁹

Physical therapy and rehabilitation provided via telehealth produced equivalent or better outcomes than in-person visits (physical function, quality of life, reduced pain, and psychological and social functioning).⁹⁰ Tele-rehabilitation was shown to be beneficial, cost effective, and satisfactory for patients with multiple sclerosis: A systematic literature review found no significant differences in primary outcomes between patients who received clinic rehabilitation and home tele-rehabilitation.⁹¹ However, researchers noted that more research is required to evaluate long-term effects.

Studies focused on cardiology found that telehealth interventions, including synchronous video visits and online coaching, reduced cardiovascular disease incidence compared with usual care.⁹² Another meta-analysis found that telehealth reduced systolic blood pressure and improved quality of life compared with usual, in-person care. However, researchers found no significant differences in body mass index.⁹³ Systematic reviews revealed that telehealth combined with in-person care significantly reduced in-hospital mortality for patients with acute myocardial infarction.⁹⁴

Patient and Provider Satisfaction

BPC's literature review showed high levels of patient and provider satisfaction with telehealth. One systematic review used system experience, information-sharing, consumer focus, and overall satisfaction as measures of patient satisfaction and found high levels of satisfaction across all these dimensions.⁹⁵ Other studies used access, timeliness, appropriateness, effectiveness, and safety as measures for patient satisfaction.

People living in rural areas were generally satisfied with telehealth as a mode of health care delivery. However, the current evidence base lacks clarity in terms of how satisfaction was defined for these studies. Researchers did find high levels of satisfaction across the following domains for telepsychiatry services: audio-visual quality of videoconferencing; accessibility of a service in one's local health care center; time and cost savings for patients; patient comfort in participating in telehealth; technical support; and operations and usability of telehealth technology.⁹⁶

Medicare beneficiaries who use telepsychiatry tended to be very satisfied (95%) across multiple domains, including convenience, comfort, and overall visit. However, a lower percentage (76%) said they were very satisfied with the technical quality of the visit.⁹⁷

Patient satisfaction was high across a variety of conditions and specialties. A [survey](#) conducted by BPC and Social Sciences Research Solutions found that 94% of adults (18+) who had a telehealth visit were satisfied with the quality of their care (Figure 3), with 80% of respondents saying they were likely to

use telehealth again.⁹⁸ Multiple studies showed particularly high levels of satisfaction for mental health services delivered by telehealth.⁹⁹ For chronic conditions, studies found that most patients were satisfied with their telehealth visit.¹⁰⁰ One study found that although there was no overall difference in patient satisfaction between in-person and virtual physical therapy, patients reported higher satisfaction when they achieved treatment goals in-person.¹⁰¹

Across specialties, studies highlighted a need for providers to build a rapport with their patients. Providers can accomplish this by stressing that telehealth can produce comparable outcomes to in-person care; presenting telehealth in positive terms rather than as a second-tier option to in-person care; conveying the partnership and collaboration with the patient; and working closely with support staff.¹⁰²

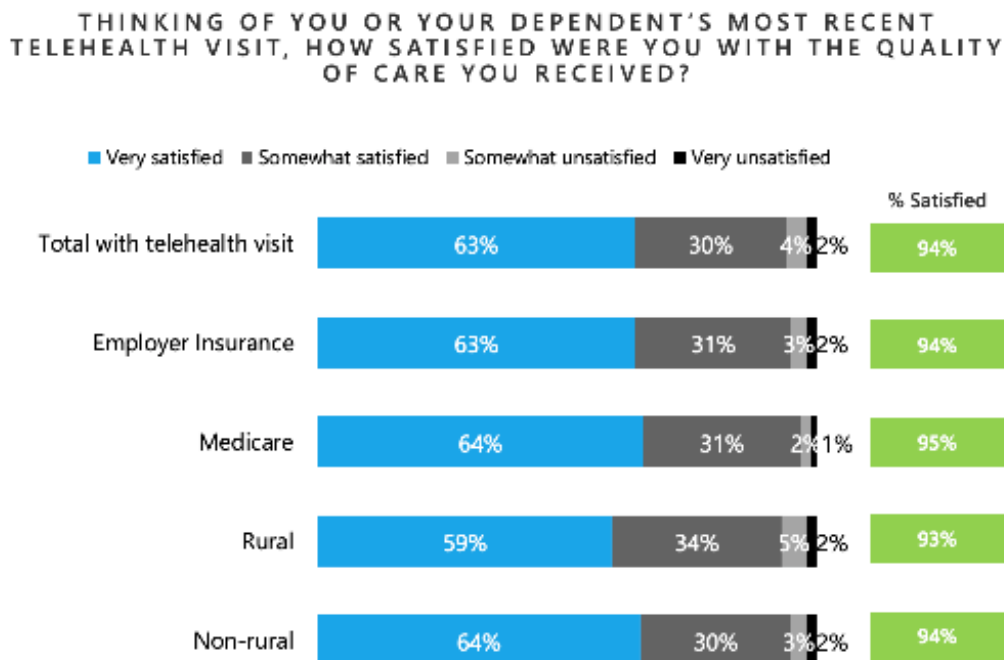
Provider satisfaction related to telehealth was also high. One meta-analysis found no differences in surgeon satisfaction for orthopedic assessments evaluating pain and function delivered via telehealth versus in-person.¹⁰³ Another study found that more than 90% of clinicians were satisfied with sound and video quality.¹⁰⁴

However, many providers have shifted services back to the office, possibly because they perceive the quality of telehealth experience as suboptimal. One-quarter of clinicians said they believed that the patient experience of a video consultation was worse than a face-to-face appointment.¹⁰⁵ The share of physicians offering both telehealth and in-person services—but recommending in-person services when possible—increased by 13 percentage points between July 2020 and April 2021.¹⁰⁶

Some studies showed that while telehealth was well accepted by most patients, some did prefer face-to-face consultations and showed resistance to video consultations.¹⁰⁸ Through surveys and in-depth interviews, researchers found that telehealth was less suitable for physical examinations or situations where the diagnosis was unknown.¹⁰⁹

Figure 3: Telehealth and Patient Satisfaction, 2021¹⁰⁷

Nearly all respondents were satisfied with their telehealth visit.



COST IMPACT

A key attraction of telehealth for federal and state governments, private health plans, and employers has been the potential for cost savings. Many have recognized the possibility to replace in-person visits with less expensive virtual visits, or to better manage conditions via telemedicine and avoid costly ED visits or inpatient stays.

Multiple factors contribute to the overall cost effectiveness of telehealth services, including the overall reimbursement rate (payer payment plus patient cost sharing), the degree to which telehealth creates new utilization, the ability of telehealth to replace or substitute for in-person care, and its impact on patient outcomes and downstream costs. The combination of these inputs ultimately determines overall cost effectiveness. Additional evidence on telehealth's impact on short and long-term patient outcomes is needed for a complete cost-effectiveness assessment.

Each factor is described in greater detail below.

Reimbursement Rate

The payer reimbursement rate is a key factor in cost effectiveness. Telehealth is less likely to be cost effective if it is paid at parity with in-person visits, which is Medicare's current policy for most providers during the PHE. If telehealth is reimbursed at a lower rate than an equivalent in-person visit, as was done before the pandemic, greater utilization would be less likely to contribute to an

overall spending increase. Said differently, if telehealth services are reimbursed at a lower rate, it is more likely to offset any cost increases from increased utilization.

Before the pandemic, most telehealth services were paid under the Medicare Physician Fee Schedule at a lower facility rate. This was the rate used to pay providers delivering care in facilities, such as hospital outpatient departments. Medicare used the facility rate rather than the higher rate for reimbursing office-based providers because it presumed the expenses associated with delivering telehealth services were lower.

As authorized by the COVID relief packages, CMS's payment policy quickly changed at the beginning of the pandemic to incentivize providers' use of telehealth. Medicare began reimbursing most telehealth services, including audio-only visits, at parity with in-person care; many state Medicaid agencies and private payers followed suit. These changes to payment policy were temporary and important for maintaining access to services during the pandemic. Long-term, however, payment parity can have major implications for the cost effectiveness of telehealth services.

Notably, several national payers continue to pay for telehealth services in Medicare Advantage and commercial plans at parity with in-person visits two and a half years into the pandemic, even though they are not required to do so. Half of all states have enacted laws that require payment parity for telehealth services (an increase from 10 in 2019); 18 states require payment parity across all payers.^{110,111} Massachusetts requires payment parity only for behavioral health services.¹¹² This change represents a huge shift in states' post-pandemic telehealth policy, as many states previously required insurers to cover telehealth services but did not stipulate payment parity.¹¹³

Parity also has implications for beneficiaries' out-of-pocket spending. In 2019, Medicare spent less than \$1 per month on telehealth services; in 2020 and the first three quarters of 2021, spending on telehealth [rose](#) to around \$12 per beneficiary per month.¹¹⁴ As the value of a telehealth visit increases (if being reimbursed at parity), beneficiaries are responsible for a higher dollar figure through co-insurance. As a result, Medicare beneficiaries have been paying more out-of-pocket for telehealth visits during the PHE.

Because telehealth services tend to be shorter, include fewer diagnostic services, and can involve fewer support staff than in-person visits, there are questions regarding the appropriate level of reimbursement.¹¹⁵ In many cases health systems can provide telehealth services at a lower cost (i.e., providers can work from home or in lower cost facilities). However, many providers and provider associations have been vocal that certain offsets to providing telehealth services, such as the need for technology platforms and IT staff, as well as the complexity of delivering multiple care modalities, must also be accounted for when developing telehealth service reimbursement rates.

Convenience and New Utilization

The degree to which the convenience of virtual care boosts usage also has a big impact on the cost effectiveness of telehealth. Conditions such as rashes and colds are common, and most patients with these ailments do not get care. On the other hand, acute conditions such as stroke or heart attacks, for which most people already receive treatment, are less prone to increased utilization.¹¹⁶

The CBO and MedPAC have expressed concern that expanded coverage for telehealth may increase spending by raising the overall use of care.^{117,118} Multiple studies have shown that the convenience of telehealth increases utilization. A commercial claims data analysis (2011–2013) found that 12% of direct-to-consumer (fully virtual provider) telehealth visits replaced visits to other providers, and 88% represented new utilization. Net annual spending on acute respiratory illness increased \$45 per telehealth user.¹¹⁹ A subsequent analysis using data from a large, commercial payer for the 2016-2019 period found that patients who made initial visits for acute respiratory infection were more likely to obtain follow-up care within seven days after direct-to-consumer provider telehealth visits (10.3%) than after in-person visits (5.9%). In both settings, approximately 90% of patients did not obtain additional care.¹²⁰

However, an increase in utilization is not intrinsically problematic; instead, it can represent new, appropriate access to services. For example, telehealth played an outsized role in [more new patients](#) receiving behavioral health services during the pandemic.¹²¹ These patients may have gone untreated before.

Substitution Effect

An important factor in analyzing the cost effectiveness and value of telehealth is its ability to replace or substitute for in-person care. Are telehealth visits adding to the volume of overall services, or are they having a substitution effect, whereby a person has a telehealth visit and does not return in-person for the same complaint? Or, for example, are virtual visits substituting for costlier emergency room stays? If telehealth services have a substitution effect, coverage of telehealth services could reduce federal spending. But if telehealth services are used in addition to in-person care, coverage would increase Medicare spending.

The [survey](#) conducted by BPC and Social Sciences Research Solutions in August 2021 suggested that access to telehealth may have kept some people out of the ED.¹²² About 1 in 7 people (14%) who used telehealth said they would have sought care in an ED or at urgent care if telehealth was not available, and more than half of those people had their primary health issue resolved.¹²³ The same survey showed that a majority of respondents (63%) said their telehealth visits were for a preventive service, routine visit for chronic illness, such as diabetes, or for prescription refills.

A study compared downstream effects for in-person versus telehealth visits using Blue Cross Blue Shield of Michigan claims data from 2011 to 2017: It

found that it was more common for patients to schedule related visits within 30 days if their episode of care was initiated via a telehealth visit rather than an in-person visit. Researchers also found that in episodes where patients had a related visit, the mean number of visits was higher for episodes of care initiated via a telehealth visit.¹²⁴

A retrospective cohort study looked at the impact of telehealth on urgent and non-urgent care for seniors who were affiliated with a health system (2015-2019). It concluded that telehealth encounters were successful in resolving urgent and non-emergent needs in approximately 85% of cases. When visits required follow-up, more than 95% were resolved in less than three visits for both telehealth and in-person cohorts. Results suggested that when telehealth is used in the context of a health system that has access to a patient's clinical record, telehealth can be an effective alternative to in-person care without increasing downstream utilization.¹²⁵

More recent data suggest that telehealth is more likely to be additive if used by patients for acute versus chronic conditions. Researchers looked at telehealth utilization from 2019 to the end of 2020 for 41 million commercially insured adults. They said that patients with acute conditions who had an initial telehealth visit were slightly more likely to have a follow-up encounter, emergency room visit, or inpatient admission, compared with those who had an in-person visit. However, patients with chronic conditions who had an initial telehealth visit were as or less likely to need follow-up care than those with an initial in-person visit.¹²⁶

Telehealth visits are also more likely to be additive versus substitutive if they are positioned as a triage tool where most patients still get an in-person follow-up visit.¹²⁷ This has implications for how health systems and commercial payers, many of whom maintain their own virtual platforms for beneficiaries, design virtual options. Telehealth visits have been found to be more cost effective if used for individuals with high clinical needs (such as nursing home residents) because telehealth has an increased ability to offset costly hospital stays. For example, a 2014 study of nursing home residents indicated that coverage of on-call telehealth physicians after-hours could generate substantial savings by deterring costly ED and inpatient stays.¹²⁸

Last, fee-for-service reimbursement for individual digital interactions with patients (e.g., portal messages, phone calls for medical advice) may also make it less likely the technology will be cost effective.¹²⁹ If providers begin billing for patient interactions that were previously not billed for separately, such as a phone call to communicate lab or test results, the care will be additive.

Impact on Patient Outcomes and Downstream Utilization

The impact of telehealth services on longer-term clinical outcomes also has implications for the cost effectiveness of the benefit. For example, telehealth services have the potential to reduce downstream utilization by allowing more-frequent, convenient touchpoints with providers to better monitor and control beneficiaries' chronic conditions.

Before the pandemic, there was considerable uncertainty around the likely utilization rates for telehealth services and their downstream effects. The CBO and other entities did not have extensive data to help them project how expanding telehealth coverage would affect federal spending in Medicare. One study using data from more than 35,000 patients in an Accountable Care Organization (ACO) between 2014 and 2017 found that the use of virtual visits reduced in-person services by 33% but increased total visits (virtual plus in-person visits) by 80% over 1.5 years. Although the use of virtual visits reduced in-person visits soon after registering with the program, the effect did not endure beyond a year.¹³⁰

Given the broad telehealth flexibilities afforded during the pandemic, formal evaluations of future spending in the Medicare population are expected to emerge. In most evaluations of telehealth, cost effectiveness is either not included or the data are poor. Additionally, when available, cost effectiveness has been largely evaluated in academic literature by condition. Therefore, for most conditions, there is limited published evidence to confirm whether the delivery of those services via telehealth is a cost-effective alternative to standard, in-person care with some exceptions—one being telestroke.

The cost effectiveness of telestroke care compared to usual post-stroke care is well documented and discussed in greater detail in a recent BPC report, [*Leveraging Digital Technology to Enable a More Equitable Distribution of the Health Care Workforce*](#).¹³¹ Telestroke is the use of telehealth specifically for stroke care; it allows physicians at tertiary care centers, often vascular neurologists, to evaluate and remotely treat stroke patients in the emergency room. This model bypasses the need to urgently transfer suspected stroke patients to larger regional hospitals, which takes time and limits the efficacy of treatment. A study of more than 150,000 patients treated for stroke found that individuals who received care at hospitals with telestroke capacity had higher rates of reperfusion treatment, which restores blood flow to blocked arteries, and lower 30-day mortality compared with those treated in hospitals without telestroke.¹³² The gains were greatest in smaller hospitals in rural areas.



Recommendations and Rationale

SECTION I: FOUNDATIONAL

Outlined below are policies that cut across service types and strengthen the delivery of telehealth services overall. Recommendations pertain to both statutory changes as well as regulatory policies aimed at the Biden administration. Given that technology issues are ever-changing, BPC's telehealth recommendations largely defer to the secretary of HHS as appropriate.

Ensure Equitable Access to Care

To ensure continued, equitable access to care, Congress should:

- Amend Section 1834(m) of the Social Security Act to permanently remove geographic restrictions for telehealth and to include the home of an individual, or wherever the patient is located, in the list of authorized originating sites.
- Permanently authorize FQHCs and RHCs to serve as distant sites by amending Section 1834(m) of the Social Security Act.

- **Incorporate audio-only telehealth services into the definition of telehealth. Beyond that, the secretary of HHS should limit audio-only services to beneficiaries with established patient-provider relationships.**
- **Make HHS’s 1135 temporary waiver authority permanent for future public health emergencies, as well as extend HHS’s current flexibilities for two years post PHE.**

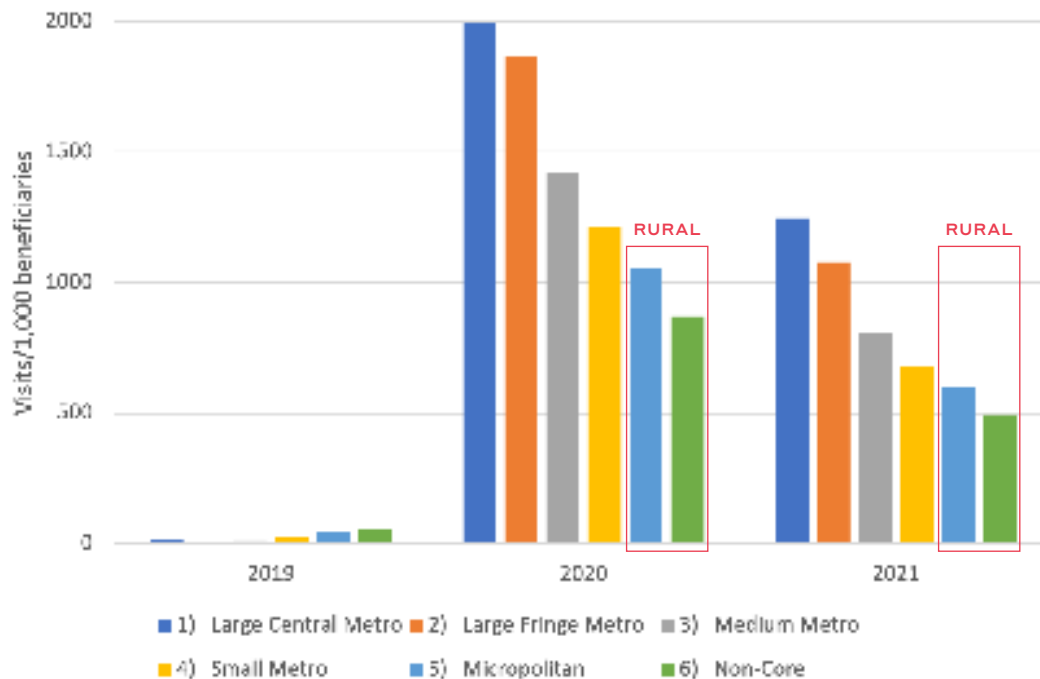
To ensure more equitable access to health care across populations, the administration and Congress should continue to maintain access to telehealth for Medicare beneficiaries regardless of where they live or their medical diagnosis. Beneficiaries encounter barriers to accessing care across geographic settings—for example, mobility issues or an inability to secure transportation. Telehealth access has the potential to address inequities and improve outcomes for all groups. Although some stakeholders believe telehealth services should be limited to select patient populations or health conditions, most stakeholders interviewed by BPC supported broad, equitable access to the benefit. To this end, BPC supports several foundational telehealth policy changes that Congress should make to ensure continued, equitable access to care for all Medicare beneficiaries.

BPC recommends Congress permanently remove geographic and site of service (originating site) restrictions for telehealth and include the home of an individual, or wherever the patient is located, in the list of authorized originating sites. All Medicare beneficiaries, regardless of where they live in the United States or their medical diagnosis, gained access to telehealth services during the pandemic. Although rural areas were the initial use case for telehealth services in Medicare, COVID-19 flexibilities resulted in a complete flip of the paradigm. As of 2021, the closer a Medicare beneficiary lived to a metro center, the [more likely](#) he or she was to use telehealth services (see Figure 4)¹³³. In 2020 and the first three-quarters of 2021, telehealth visit rates were highest for Medicare beneficiaries living in large metro and large fringe metro areas.

Stakeholders highlighted the importance of allowing all Medicare beneficiaries to access routine care from their homes during the height of the pandemic to keep the public safe and to limit the community spread of COVID-19. Stakeholders also largely agreed that even beyond the pandemic, accessing care from home was an important benefit for patients. The opportunity to deliver care to people in their homes allowed some providers interviewed to deliver services to people in farming communities who had never accessed behavioral health services before due to stigma. Given the convenience, issues of stigma, patient mobility, and access, stakeholders strongly supported continuing to allow beneficiaries to access care from home beyond the PHE. BPC recommends Congress permanently include the home of the individual, or wherever the patient is located, in the list of authorized originating sites.

Figure 4: Telehealth Visits per 1,000 Medicare Beneficiaries by Urbanicity, 2019-2021¹³⁴

Utilization of telehealth was directly, inversely related to a beneficiary's distance from an urban center.



Note: Beneficiaries living in (5) micropolitan and (6) non-core regions are considered rural.

Congress should also amend Section 1834(m) of the Social Security Act to ensure that FQHCs and RHCs permanently qualify as distant site providers for telehealth beyond the expiration of the PHE. CMS has developed workarounds regarding regulations (e.g., CMS included a new interpretation of audio-only and live video telemental health services provided by FQHCs and RHCs in the 2022 Physician Fee Schedule final rule). However, the most effective fix would be a legislative change to ensure these providers are permanently able to receive reimbursement for telehealth services. Because these providers disproportionately serve at-risk populations, in particular a large number of racial and ethnic minorities, their exclusion from telehealth reimbursement would exacerbate inequities in access to telehealth services in the United States.

In addition, BPC recommends that Congress permanently incorporate audio-only telehealth services into the definition of telehealth. Audio-only telehealth services, while more limited in their clinical utility, continue to be critical for a subset of vulnerable Medicare beneficiaries who lack broadband access or face technology barriers. Recently, CMS clarified that states can make Medicaid audio-only telehealth permanent beyond the PHE and receive federal matching funds for these services.¹³⁵

However, as is described further in this report, BPC also recommends that HHS adopt additional restrictions on audio-only services, such as strictly limiting them to established patient-provider relationships. Although most stakeholders supported audio-only services at the height of the pandemic, questions remained whether such services should continue unrestricted for all beneficiaries beyond the PHE. Stakeholders raised concerns over the quality of these services, their overuse, and their susceptibility to fraud.

For a complete description of BPC's recommended approach to established patient and in-person visit requirements by type of care delivered and modality (two-way video or audio-only), see the Appendix.

Additionally, Congress should make HHS's authority to issue temporary waivers during a PHE permanent. Congress gave HHS authority under Section 1135 of the Social Security Act to waive telehealth restrictions, but only during the COVID-19 pandemic. Extending the secretary's authority permanently during public health emergencies, including the initiation or sunset of waivers, would give the secretary the flexibility to respond to emerging risks and help HHS prepare for the next PHE.

Lastly, Congress should allow the department to extend the current telehealth flexibilities an additional two years beyond the current PHE, as is recommended later in this report for the continuation of primary care and specialty services. (Behavioral health services have already been extended on a permanent basis.) A two-year extension would allow the agency to test the current telehealth flexibilities outside of a PHE and generate the evidence needed to inform permanent telehealth policy.

The Advancing Telehealth Beyond COVID-19 Act ([H.R.4040](#)) is bipartisan legislation that passed in the House in July 2022 and extends telehealth flexibilities through December 31, 2024. The CBO estimated H.R.4040's extension of the current telehealth flexibilities would cost Medicare \$1.45 billion for one year.¹³⁶

Ensure Benefit Transparency and Consumer Protections for Telehealth Services

To guarantee benefit transparency and consumer protections, HHS should:

- **Ensure telehealth benefits are clearly communicated to beneficiaries, appropriate to be delivered via telehealth, and consented to by the beneficiary. Audio-only visits should always be patient-initiated.**
- **Require providers delivering telehealth services to have the capacity to deliver in-person services or else ensure that beneficiaries have the option to schedule in-person visits with local providers within a reasonable timeframe.**

- **Distinguish between traditional and fully virtual providers in Medicare, either via a new modifier, provider category, or another approach determined appropriate by the secretary, in order to evaluate cost and quality outcomes.**
- **Resume enforcement of penalties on providers for noncompliance with HIPAA rules for technology use. HHS's OCR has already informed providers that oversight will resume at the end of the PHE.**
- **Resume enforcement of cost-sharing expectations for beneficiaries' telehealth and audio-only visits, which OIG halted during the pandemic, and inform providers and beneficiaries this activity will resume.**
- **Monitor the appropriate use of virtual check-ins versus telehealth appointments and consider aligning current reimbursement policy regarding virtual check-ins with telehealth services.**

Telehealth policies should place a high value on consumer protections. Consumers must understand their telehealth benefits and be protected against possible misuses of telehealth that could undermine the quality of patient care. The virtual nature and convenience of telehealth, and the resulting electronic exchange of health information, also make this type of health care vulnerable to data security breaches. To limit security risks, policies must ensure that personal health information is private and secure.

To begin, CMS should clearly communicate telehealth benefits to Medicare beneficiaries, including through the Medicare.gov website and printed benefit information. CMS's 2023 Physician Fee Schedule Proposed Rule proposes making delivery of telehealth services part of the Physician Compare Finder tool on Medicare's website. CMS should ensure services delivered via telehealth are appropriate and consented to by the patient—never delivered via telehealth for the convenience of the provider. Telehealth visits should always be patient-initiated to shield beneficiaries from harm, as reimbursement for these services requires patients to pay coinsurance. If a provider intends to bill a patient or the patient's health plan for an audio-only telehealth service, the provider must obtain patient consent for the billing in advance of the service being delivered. Providers delivering telehealth should attest that services are delivered in line with these requirements, and HHS should conduct provider audits.

CMS should require providers delivering telehealth services to have the capacity to provide services in-person, or else be able to refer beneficiaries to providers who can deliver in-person services within a reasonable timeframe, to be determined by the secretary. Such a requirement would provide a critical consumer protection to ensure that fully virtual providers can facilitate the transition of a patient to an available in-person treatment provider, when necessary. We know that some subset of beneficiaries who access virtual care will require in-person care, either urgently or as a follow-up appointment.

BPC recommends that CMS develop an approach to ensure providers delivering virtual services have the protocols in place to transition patients to in-person services within a reasonable timeframe when they need to see a provider in-person. This should, minimally, be done for beneficiaries with urgent or emergent conditions. One option would be to require fully virtual providers on the front-end to sign formal agreements with local providers to whom they can refer patients. Another option would be for fully virtual providers to have a robust care management solution in place that helps connect beneficiaries to services in their area, as needed. Ultimately, CMS will have to develop a way to identify and monitor fully virtual providers to ensure they are appropriately connecting beneficiaries to in-person care.

Members of Congress from both parties have expressed support for similar recommendations requiring providers delivering telemental health services to have the ability to either deliver the services in-person or to refer the patient to in-person services.¹³⁷ Although the draft legislative language applies specifically to telemental health services, instituting a similar guardrail for all telehealth services would ensure that the beneficiary's preference, and not the provider's convenience, determines whether the service is provided via telehealth or in-person.

Interestingly, several fully virtual providers have moved to partner with local providers this past year. In July 2022, Amazon announced plans to acquire One Medical, an innovative, membership-based primary care practice, to expand into a hybrid digital and in-person platform (the company later announced they were shutting down Amazon Care, their primary care telehealth startup).¹³⁸ Also, telehealth company Amwell is working with CVS Health to roll out the retail drugstore's new virtual primary care services.¹³⁹

To develop policy with respect to fully virtual providers, HHS must be able to distinguish between traditional and fully virtual providers operating in Medicare through the claims data. Before beneficiaries gained broad access to telehealth services from home, fully virtual providers did not have the option to bill Medicare. Now, with broadened telehealth flexibilities in place (which BPC advocates remain for an additional two years' post-PHE), BPC recommends that HHS determine the most appropriate way to identify these providers. This could be accomplished via a new modifier, provider category, or another approach determined appropriate by the secretary. It will be important to understand the impact of fully virtual providers on beneficiaries' care across services and the Medicare program. The secretary should determine specific requirements, such as whether to cap the percentage of visits a provider can deliver via telehealth before being considered a virtual provider.

HIPAA is designed to protect patient data and is another important consumer protection. During the public health emergency, HHS's OCR issued guidance on when to waive sanctions and penalties for providers who were in noncompliance with the HIPAA privacy rule. This waiver was intended to

encourage telehealth uptake by allowing providers who were not in compliance with HIPAA to use communications apps with their patients. Given the wide availability of affordable HIPAA-compliant technologies, OCR should reinstate the HIPAA requirements following the end of the PHE, as they have already proposed to do. Popular video platforms such as Zoom and Skype now have HIPAA-compliant offerings that did not exist at the outset of the pandemic. In June 2022, OCR issued guidance on how providers could deliver audio-only telehealth services in a way that is consistent with HIPAA requirements.¹⁴⁰

Also, OIG should begin re-enforcing cost-sharing expectations for beneficiaries' telehealth and audio-only visits and issue guidance giving notice to providers. OIG previously suspended enforcing certain anti-kickback provisions for the duration of the pandemic. However, as evidenced by BPC's [Medicare data analysis](#), beneficiaries continued to be charged copays and coinsurance for telehealth services received. As telehealth utilization increased at the beginning of the pandemic, and as services were reimbursed at parity with in-person visits, Medicare beneficiaries have been paying higher out-of-pocket costs for telehealth visits. Out-of-pocket spending [went](#) from 0.02% of the total paid for telehealth services, to 2.0% of the total in 2020, and to 1.8% in 2021.¹⁴¹ Additionally, reinstating out-of-pocket costs for telehealth has the potential to deter overuse, because beneficiaries will themselves evaluate the value of a service delivered virtually.

Last, CMS should monitor the appropriate use of virtual check-ins versus telehealth visits beyond the PHE. For established patients, it is unclear how many providers would opt to schedule virtual check-ins given the existing telehealth flexibilities, especially around audio-only telehealth. Additionally, CMS should also consider aligning the current payment protections in place for virtual check-ins to the reimbursement of telehealth services, for the protection of double payment. As described earlier in the report, virtual check-ins were established by Medicare before the pandemic—these are brief, 5- to 10-minute, patient-initiated phone calls or video chats with providers. Consumer advocates interviewed for this report raised concerns that patients could face two copays if an initial telehealth visit cannot resolve the concern and becomes an in-person visit. To mitigate this risk, CMS should consider adopting the same policy of denying payment for a telehealth visit if it is for the same medical issue as a medical visit within the previous seven days, or if it leads to a visit for the same issue within the next 24 hours, with the same provider.

Strengthen Fraud, Waste, and Abuse Protections

To strengthen FWA protections, Congress and the administration should:

- **Ensure that OIG and CMS have sufficient funding to modernize their capabilities and proactively track FWA for telehealth and audio-only services.**

- **Require audits of outlier providers delivering a high volume of high-cost DME and high-cost laboratory tests via telehealth or for other services determined by the HHS secretary to be prone to fraud, waste, or abuse.**
- **Require all high-cost DME and high-cost laboratory tests be ordered in the context of established patient-provider relationships, except for providers participating in APMs with two-sided risk.**

High-cost DME and lab tests have been targets of fraud during the COVID-19 pandemic. In July 2022, OIG released a new [fraud alert](#) to caution providers about telehealth arrangements due to the rise of fraud and kickback schemes.¹⁴² These schemes involved telemedicine companies paying practitioners in exchange for prescribing medically unnecessary services to patients, such as DME, genetic testing, wound care items, or prescription medications (in violation of the federal anti-kickback statute).¹⁴³

In 2019, the U.S. Department of Justice found that fraudsters paid clinicians to order and bill Medicare for unnecessary DME and lab tests via telehealth, costing the Medicare program more than \$1.2 billion.¹⁴⁴ OIG clarified that the perpetrators did not bill for sham telehealth visits, but that they billed fraudulently for other items or services, such as DME and genetic tests.¹⁴⁵

Congress must ensure that OIG and CMS have sufficient funding to modernize their capabilities and proactively track FWA for telehealth and audio-only services. BPC interviewed major commercial insurers about how their best practices involving FWA evolved over the course of the pandemic to better monitor telehealth and audio-only claims. Several mentioned reviewing claims on the front end to identify suspicious activity before payment, as well as creating alerts within their rule-based and AI analytic models to detect fraud. An OIG report released in September 2021 found major gaps in state Medicaid agencies' evaluation and oversight of tele-behavioral health services, such as their lacking monitoring and oversight specific to telehealth.¹⁴⁶ Clear opportunities exist to strengthen FWA monitoring for telehealth across both state and federal programs.

Additionally, CMS should require audits of outlier providers delivering a large volume of high-cost DME and laboratory tests via telehealth or for other services prone to fraud, waste, or abuse. For example, if claims data indicate that a provider delivering telehealth prescribed over a certain threshold, an audit would be triggered. HHS should also require all high-cost DME and laboratory tests be ordered in the context of established patient-provider relationships, except for providers participating in two-sided risk APMs. In 2020 and the first three quarters of 2021, approximately 95% of tele-primary care visits were in the context of established patient relationships.¹⁴⁷

To the extent possible, targeted policies should seek to safeguard against costly fraud without creating barriers to necessary care. Provider-directed guardrails intended to mitigate telehealth waste, fraud, and abuse will uncover potentially fraudulent activity without limiting consumer access to care.

Incentivize Provider Participation in Value-Based Care

To incentivize provider participation in value-based care, the administration should:

- **Permanently maintain all current telehealth and audio-only flexibilities for providers participating in APMs with two-sided risk arrangements, including using audio-only visits and establishing virtual-first relationships with specialists.**

Adoption of value-based payment models has increased substantially over the past decade across Medicaid, Medicare, and commercial contracts. COVID-19 reinforced strong interest in value-based payments, given the limited ability of fee-for-service reimbursement to support providers during the pandemic. Additionally, in a value-based health care system, providers can invest their resources in ways they believe will produce the best clinical and quality outcomes. Because APMs require providers to assume some financial risk, providers have a reason to be efficient and incentive to use telehealth appropriately.

In 2018, researchers found that hospitals participating in ACOs and bundled payment risk arrangements were more likely to provide telehealth services.¹⁴⁸ These APMs encourage organizations to use resources in an efficient manner. By 2030, CMS expects that all beneficiaries in traditional Medicare will be treated by a provider participating in a value-based model with accountability for quality and total cost of care.¹⁴⁹

During the pandemic, providers participating in value-based payment arrangements were better positioned to leverage other revenue sources (e.g., shared savings, monthly capitated payments) for financial stability. A cohort study of Medicare Advantage enrollees reported that telehealth use rose faster and reached higher absolute levels during the pandemic among patients attributed to primary care organizations participating in advanced value-based payment models; this was despite fee-for-service organizations facing the strongest near-term financial incentive to increase telehealth utilization.¹⁵⁰ Organizations participating in APMs had already developed new capabilities as a part of their transition (e.g., care management staff, more robust data infrastructures) and were able to modify or redeploy those capabilities for the care reforms needed during the pandemic.

Before the COVID-19 PHE, CMS granted clinicians in certain APMs additional flexibility to bill for telehealth services. CMMI has statutory authority to waive

most of Medicare’s statutory requirements to test APMs. Benefits for this flexibility include using telehealth as a carrot to incentivize fee-for-service providers to move further down the APM continuum.

Over the last decade, providers participating in value-based payment models had fewer Medicare beneficiaries from underserved and rural communities in their care, and CMMI has committed to addressing barriers to participation for providers serving a high proportion of those two populations. Telehealth flexibilities could be positioned, alongside a suite of other financial incentives, to entice providers into value-based payment.

Recognizing the financial incentives that APM providers face, as well as the additional flexibility already afforded to these providers, stakeholders interviewed by BPC broadly agreed that providers participating in two-sided risk arrangements should permanently maintain all current telehealth and audio-only flexibilities. This would include the flexibility to deliver audio-only telehealth services to beneficiaries across all services and the ability to establish virtual-first relationships with specialists (meaning, specialists are able to start treatment relationships virtually with new, as well as established, patients).

Improve Data Quality for Future Policymaking

To improve data quality for evidence-based policymaking, CMS should:

- **Develop additional guidance for the billing of telehealth and audio-only services to ensure appropriate coding and billing uniformity.**
- **Assign a medical specialty to advanced practice nurses and physician assistants to appropriately differentiate primary and specialty care.**
- **Prohibit “incident to” billing by any provider who can bill Medicare directly.**

MedPAC’s March 2022 report to Congress recommended that HHS require health care organizations to report more information on telehealth use to help policymakers determine the future of virtual care.¹⁵¹ To generate reliable evidence, CMS should work to simplify telehealth billing and educate providers about billing practices. Providers face myriad billing codes and modifiers when seeking reimbursement for telehealth services. Given the dramatic increase in the number of providers delivering telehealth and audio-only services since the pandemic began, HHS should make every effort to educate providers and ensure billing accuracy. Guidance for providers should clarify how to navigate billing Medicare virtual check-ins versus audio-only telehealth visits as the nation exits the PHE. In CMS’s 2023 Physician Fee Schedule Proposed Rule, CMS proposes simplifying audio-only services, including by making audio-only a modifier across all codes.¹⁵²

An additional opportunity to improve claims data for analysis and future policymaking is to begin differentiating between primary care and medical

specialties for advanced-practice nurses and physician assistants. Although this issue is not limited to telehealth services, Medicare categorizes advanced practice clinicians as primary care providers regardless of their actual specialty. For example, physician assistants and nurse practitioners in surgical settings are classified as primary care providers; this may interfere with Health Professional Shortage Area (HPSA) determinations and workforce needs by overestimating the number of primary care providers in an area. The HHS secretary should direct CMS to assign a specialty classification to these providers.

Last, to help policymakers understand who is delivering video and audio-only visits and in what quantity, the administration should prohibit “incident to” billing by any provider who can bill Medicare directly. Incident to billing refers to a clinician such as a physician assistant billing for services under a supervising physician, versus under their own identification. MedPAC previously recommended that Congress require advanced practice nurses and physician assistant to bill the Medicare program directly and end incident to billing.¹⁵³ Ending this practice will support research as well as efforts to detect and investigate fraud. CMS’s 2023 Physician Fee Schedule Proposed Rule indicates incident to billing will no longer be an option after the PHE.

Right-Size Reimbursement for Telehealth Services Post-PHE

Following the end of the PHE, CMS should:

- **Leverage its current process to determine appropriate reimbursement for video-based tele health and audio-only services. Post-PHE, telehealth visits will likely be paid as a fraction of in-person visits. CMS should also implement a differential payment between audio-only and video visits.**

BPC recommends that CMS leverage its current process using the Medicare Physician Fee Schedule to determine appropriate reimbursement for video-based telehealth and audio-only services. The payment schedule varies according to the service provided and the type of health care provider involved. We estimate that post-PHE, telehealth visits will be paid as a fraction of in-person visits.

Since the pandemic, Medicare has reimbursed for two-way video and audio-only telehealth services at parity to in-person visits for most providers. Paying for telehealth services at parity can be an important tool for increasing access to care, especially for behavioral health services during what is arguably a growing mental health and substance use crisis in the United States. Paying telehealth services at parity can also help retain providers in network at a time when many behavioral health providers are outside insurance networks—citing insufficient reimbursement and complicated paperwork.

However, payers and policymakers are concerned that payment at parity likely represents a mismatch between provider costs to deliver care and actual reimbursement rates. On the one hand, providers delivering more virtual services may benefit from having to maintain less office space, fewer staff, and less supplies. Also, as mentioned earlier in this report, patients are more likely to keep and not cancel telehealth appointments. This helps providers operate with fewer losses and maintain higher margins. On the other hand, increases in technology spending to support a practice's growth in virtual care can offset these cost savings.

Payment parity may also rebalance provider incentives in a way that discourages providers from offering as many or any in-person health care services, ultimately limiting consumer access to in-person services over time. There is anecdotal evidence from several state officials that behavioral health providers in their states have moved to fully virtual practice during the pandemic and may not return to in-person care. This is especially of concern in states where payment parity requirements have been legislated, as is currently the case in half of states to date.¹⁵⁴ Providers offering telehealth services exclusively over a virtual platform could affect the availability of in-person services and exacerbate disparities for several reasons, including:

- Limited access for patients with technology-related barriers who want in-person care;
- Decreased continuity of care if patients see different providers through direct-to-consumer applications;
- Increased difficulty integrating and coordinating behavioral health care and primary care; and
- Challenges for patients who have complex conditions and need or want to be seen in-person for their care.

Discontinuing payment parity and offering a lower reimbursement rate for telehealth will also encourage providers to only use telehealth when clinically appropriate; this will encourage them to set up proper triage to ensure they are delivering services in suitable situations. However, too low a reimbursement may deter providers from utilizing telehealth services, even when they would be clinically appropriate. Additionally, without payment parity, telehealth has the potential to create cost savings if it can substitute for in-person services and direct care out of high-acuity settings.

One consideration CMS will need to address when right-sizing reimbursement for telehealth services is the difference in costs for fully-virtual telehealth providers to deliver care compared to providers with blended in-person plus virtual capabilities.

Ultimately, patients should have the ability to choose whether they see their provider in-person or via telehealth. Payment policies should not only incentivize providers to make an initial investment in telehealth, but also ensure that providers maintain access for patients who prefer or require in-person visits. As described earlier in this report, BPC supports policies that require telehealth providers to have the ability to deliver in-person services to Medicare beneficiaries or to refer patients to in-person services within a reasonable timeframe.

BPC's [analysis](#) of Medicare telehealth utilization included potential spending effects on the Medicare program associated with extending certain telehealth flexibilities once the PHE ends. BPC estimated that before the pandemic, non-facility based average spending for tele-behavioral health services was approximately 57% of in-person services, for the same service. BPC strongly recommends that post-PHE, the reimbursement for tele-behavioral health services remain above pre-pandemic levels, especially given the evidence of efficacy for tele-behavioral health services as well as the growing need for these services. However, BPC also recommends that reimbursement for tele-behavioral health services post-PHE be less than that of in-person care, because of concerns about risks to the availability of in-person care.

If Medicare were to reimburse for tele-behavioral health services between 75% and 85% of in-person services, with no additional guardrails, BPC estimates the Medicare program could expect to spend between \$548.4 and \$621.5 million in 2023.¹⁵⁶ This would amount to between a \$19.84 and \$22.48 per beneficiary per year cost. This spending estimate, as well as those which follow for primary care and other specialty services, do not factor in any offsets.

BPC estimated that prior to the pandemic, non-facility based average spending on tele-primary care was approximately 72% of in-person services, for the same service.¹⁵⁷ Based on utilization and spending analyses, BPC recommends that post-PHE reimbursement for tele-primary care services also remain above pre-pandemic levels but below parity with in-person care to maintain appropriate access to care. If Medicare were to reimburse for tele-primary care services between 75% and 85% of in-person services, with no additional guardrails, BPC estimates the Medicare program could expect to spend between \$1.003 and \$1.137 billion in 2023.¹⁵⁸ This would amount to between a \$36.29 and \$41.13 per beneficiary per year cost.

BPC recommends that for tele-specialty care services that were authorized before the pandemic, CMS should consider whether it is appropriate to return to pre-PHE reimbursement levels, with potential adjustments for inflation. If the Medicare program extends telehealth flexibilities for specialty services between 75% and 85% of parity once the PHE ends, with no additional guardrails, BPC estimates the Medicare program could expect to spend between \$852.9 and \$966.6 million in 2023.¹⁵⁹ This would amount to between a \$30.85 and \$34.97 per beneficiary per year cost.

Additionally, BPC strongly recommends Medicare implement a differential payment between audio-only and video visits. As described earlier in this report, we do not have sufficient evidence that audio-only visits are of comparable quality to in-person or video. While the modality should remain a viable option for individuals with difficulties accessing care, we do not believe the effort associated with phone visits merits comparable payment. Recently, researchers found that across 25 different studies of telehealth rates during the pandemic, audio-only visits ranged from 9% to 98% of the sample.¹⁶⁰ This level of discrepancy points to not only problematic coding and differences across patient populations and clinical settings, but also to questions about how providers are using the modality. Given quality, coding, and fraud concerns, BPC supports a lower reimbursement for audio-only services than for in-person and audio/visual telehealth services.

Medicare spending on telehealth remains a small percent of overall spending. For the outpatient codes BPC examined, telehealth spending was between 1.5% and 3.3% of total spending in 2020 and 2021, and this number is likely to decline once payment parity is removed. By the third quarter of 2021, teleprimary care [accounted](#) for only 4% of spending on primary care services.¹⁶¹ Notably, 2021 utilization and spending patterns reflect an environment where payment parity exists for in-person and telehealth services. Without payment parity, the utilization, and therefore the spending on telehealth, will likely decline.



SECTION II: BEHAVIORAL HEALTH

The behavioral health needs of older adults are often not identified or adequately addressed. The following recommendations build upon actions that Congress and the administration have already taken to ensure access to mental health and substance use services via telehealth for Medicare beneficiaries.

Refine Existing In-Person Visit and Established Patient Requirements

To refine access to tele-behavioral health services:

- **Congress should repeal in-person visit requirements for telemental health services.**
- **CMS should implement established patient requirements for audio-only behavioral health services. Patients should be allowed to establish a patient-provider relationship via video for behavioral health services.**

The pandemic exacerbated mental health and substance use issues in the United States, making patient access to quality, mental health services even more critical. Approximately 4 in 10 adults reported symptoms of anxiety and depression in January 2021—nearly four times as many as before the pandemic started and more than a quarter of young adults, while 22% of essential workers reported suicidal thoughts.¹⁶² BPC recommends Congress remove the in-person visit requirements for telemental health services, given the worsening mental health, wide gaps in access to behavioral health providers nationally, especially

in rural America, and the large body of evidence showing mental health services delivered via telehealth are largely comparable to in-person care.¹⁶³

In December 2020, Congress passed the Consolidated Appropriations Act of 2021 ([P.L.116-260](#)), which made access to telemental health services for Medicare beneficiaries permanent.¹⁶⁴ The legislation required in-person visits by mandating that these visits would not be reimbursed if the provider did not see the patient within the six-month period before the telehealth service began, as well as during subsequent periods, as determined appropriate by the HHS secretary.

CMS subsequently finalized the 2022 Physician Fee Schedule rule. The agency outlined exceptions to the in-person visit requirements, including when the patient is located at a qualifying originating site in an eligible geographic area (e.g., a practitioner office in a rural HPSA); if SUD is diagnosed; or the patient has co-occurring mental health disorders.¹⁶⁵ Additionally, the in-person visit requirement will not apply for a 12-month period if the patient and practitioner agree that the benefits of an in-person, non-telehealth service outweigh the risks and burdens associated with an in-person visit, and if the basis for that decision is documented in the patient's medical record. The rule is set to go into effect five months after the federal PHE ends.

Although BPC welcomes the flexibility and exceptions CMS developed around the in-person telemental health requirements, current evidence shows that telemental health visits are generally comparable in quality to in-person mental health visits for many behavioral health conditions. Evidence that predates the pandemic, and largely rests on the experience of telepsychiatry at the Department of Veterans Affairs, has demonstrated that telepsychiatry videoconferencing is of comparable quality to treatment delivered in person. Research also suggests that health care costs associated with treatment for depression did not differ between the virtual and in-person delivery methods and could be cost effective.^{166,167,168} Importantly, the burden of in-person visit requirements falls disproportionately on those living in rural areas who lack access to behavioral health providers (see Figure 5), must travel longer distances for care, or face the stigma of accessing in-person behavioral health services in small communities.

Bipartisan legislation has been introduced, the Telemental Health Care Access Act of 2021 ([H.R.4058](#), [S. 2061](#)), that eliminates in-person visit requirements for Medicare coverage to telemental health services.¹⁶⁹ Under this legislation, beneficiaries would no longer have to have previously received in-person services, nor would they have to continue to receive in-person services at any specified interval. Additionally, the Secretary should retain the ability to add an in-person visit requirement for tele-behavioral health services should new evidence emerge.

Figure 5: U.S. Counties Without Behavioral Health Providers by Urban/Rural Divide, 2015¹⁷⁰

Census division	Psychiatrists		Psychologists		Psychiatric NPs	
	Provider/100,000 population	% of Counties without provider	Provider/100,000 population	% of Counties without provider	Provider/100,000 population	% of Counties without provider
Overall U.S.	15.6	51	30.0	37	2.1	67
Metropolitan	17.5	27	33.2	19	2.2	42
Non-metropolitan	5.8	65	13.7	47	1.6	81
Micropolitan	7.5	35	16.8	19	2.1	60
Non-core	3.4	80	9.1	61	0.9	91

BPC also recommends that CMS implement established patient requirements for all audio-only services following the end of the PHE. While audio-only visits were an important access point for many during the pandemic, the quality of audio-only care, especially when rendered outside of an existing patient-provider relationship, has yet to be adequately studied. Although some audio-only therapy sessions were found to be clinically effective before the pandemic, they were significantly shorter than those conducted face-to-face. By 2021, almost 1 in 5 telehealth services were delivered to Medicare beneficiaries via audio-only.

Continue to Evaluate Controlled Substance Prescribing

To ensure high-quality treatment for individuals with substance use disorder:

- For non-hospice, non-cancer patients, CMS should require an in-person examination by the prescriber or a colleague in the same practice for the specific issue before prescribing opiate pain medications, or other substances determined by the secretary to be prone to abuse.
- Congress should require HHS to complete a formal evaluation of controlled substance prescribing behavior via telehealth, including MOUD.

Since the start of the COVID-19 pandemic, the suspension of the Ryan Haight Online Pharmacy Consumer Protection Act of 2008 requirements has allowed qualified MOUD prescribers to initiate buprenorphine treatment for opiate use disorder via audio-only or audiovisual telehealth visits without first having an in-person medical exam. This policy change allowed for critical treatment to continue during the pandemic, especially important given that more than 100,000 people died from an overdose in the 12 months ending April 2021 an almost 30% increase over the previous year.¹⁷²

BPC has previously recommended removing the special licensing requirement—the Drug Addiction Treatment Act (DATA) 2000 Waiver, or X Waiver—for health care providers to prescribe buprenorphine.¹⁷³ In 2018,

40% of counties in the United States did not have a single provider with an X-Waiver to prescribe buprenorphine.¹⁷⁴ BPC's Opioid Crisis Task Force released a [report](#) in April 2022 that also recommended the Department of Justice use its existing legal authority to create a special registration for eligible providers prescribing via telehealth.¹⁷⁵ The Ryan Haight Act called for the U.S. Drug Enforcement Administration, within the Department of Justice, to create a special registration through which telemedicine providers could be exempted from the in-person requirement for prescribing controlled substances. However, this registry, has yet to have rules promulgated despite the Ryan Haight Act being passed in 2008. This exemption could expand patient access to treatment while upholding an enforcement mechanism to limit the overprescribing of controlled substances.

Payers and providers interviewed for this report supported retaining PHE flexibilities for MOUD prescribing beyond the PHE. A study found that by early 2021, half of all veterans who received buprenorphine to treat opioid use disorder relied on phone visits and the rapid shift to virtual visits since the start of the pandemic; this option kept people from dropping out of care.¹⁷⁶ However, some stakeholders interviewed expressed concerns that accessing treatment via phone could lead to misuse and overprescribing of controlled substances. Recent reports have emerged that some venture-backed startups are taking advantage of looser pandemic rules to prescribe medications such as Adderall and ketamine.^{177,178} Others have raised concerns about the growing availability of weight-loss drugs via telehealth.¹⁷⁹

When the PHE ends, BPC recommends targeted adjustments to the flexibilities involving controlled substance prescribing by balancing continued access to critical services with concerns of misuse. BPC supports CMS's 2023 Physician Fee Schedule Proposed Rule to permit the intake of patients into opioid treatment programs via two-way video telehealth visits, and to allow for intake via phone only if the technology is unavailable to the beneficiary. As discussed previously, BPC strongly supports audio-only visits in the context of established patient-provider relationships. For patients who are not in hospice or receiving cancer treatment, CMS should require an in-person physical examination by the prescriber, or a colleague in the same practice, for the specific issue before prescribing opiate pain medications, or other substances determined by the secretary to be prone to abuse. This recommendation is in line with the Ryan Haight Act requirements to have at least one in-person medical evaluation before a provider can issue a prescription for controlled substances via telehealth, which will resume at the end of the PHE.

While more research has emerged recently around accessing SUD treatment via telehealth since the beginning of the pandemic, Congress should request HHS complete a formal evaluation of controlled substance prescribing behavior via telehealth, including medications for opioid-use disorder, as an assessment of the evidence during the pandemic. This evaluation should follow the end of the PHE declaration to adequately capture what happened with controlled substance prescribing during the pandemic.



SECTION III: PRIMARY CARE

At the beginning of the COVID-19 PHE, telehealth was essential for maintaining access to services; nearly one-third of all Medicare primary care visits were provided via telehealth by the second quarter of 2020.¹⁸⁰ As of late 2021, primary care visits continued to be the largest share of all telehealth visits for Medicare beneficiaries—representing approximately 39% of telehealth visits in the first three quarters of the year.¹⁸¹

Extend Access to Tele-Primary Care Services for Two Years Post-PHE

To support evidence-based policymaking, Congress should:

- **Grant waiver authority to HHS to extend access to tele-primary care services for Medicare beneficiaries for two years following the end of the PHE and require MedPAC to complete a formal evaluation of the impact on access, quality, patient outcomes, and cost.**

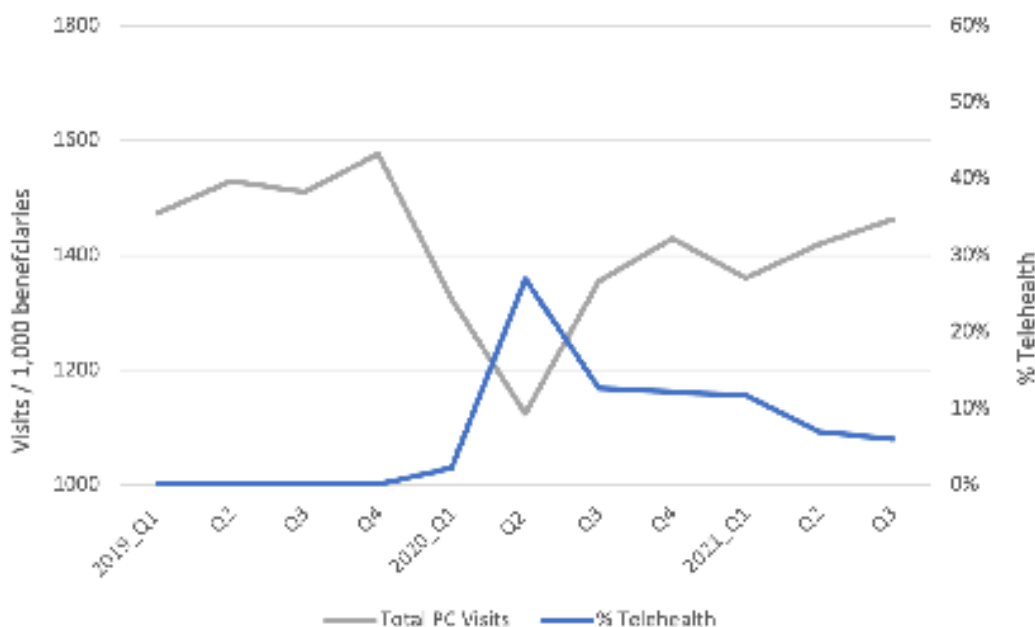
High utilization rates for tele-primary care services during the pandemic, coupled with a need for additional evidence, warrant an extension of flexibilities to study the impact of, and to develop best-use cases for, hybrid models of care. Early studies show that primary care delivered via telehealth has the potential to create positive outcomes, but additional analyses—especially in a post-pandemic world—would contribute to the evidence base and confirm which services and populations are best suited for telehealth. BPC recommends a two-year extension of access to tele-primary care services for Medicare beneficiaries to allow researchers and regulators to collect data, publish findings, and develop permanent policy.

A two-year extension of primary care flexibilities could also help alleviate problems associated with the primary care physician shortage, if providers are able to deliver care across state lines. A recent Primary Care Collaborative survey showed that nearly 45% of general practitioners saw patients who experienced worsening chronic conditions because they lacked access to primary care during the pandemic. Moreover, the United States has more than 7,500 designated shortage areas of primary care health providers.¹⁸² Although telehealth may not solve underlying shortages, it can help more equitably distribute the health care workforce by giving patients in shortage areas access to primary care practitioners.

Virtual visits increased sharply in 2020, but this growth was not enough to make up for the overall drop in in-person care in the first two years of the pandemic.¹⁸³ In other words, patients may have delayed needed care due to pandemic precautions even if a virtual option was available. Between the second quarters of 2019 and 2020, primary care visit rates for Medicare beneficiaries (including in-person and telehealth services) [declined](#) by approximately 27% (see Figure 6).¹⁸⁴ Analyses found that primary care visits decreased by 21.4% in the second quarter of 2020 compared with average visit volumes for previous years.¹⁸⁵ However, tele-primary care visits [represented](#) approximately 39% of telehealth visits for Medicare beneficiaries in the first three quarters of 2021—constituting the largest share of all telehealth visits.¹⁸⁶

Figure 6: Medicare Beneficiaries’ Total Primary Care Visits and Percent Telehealth, 2019-2021 ¹⁸⁷

Although tele-primary care use increased sharply in 2020, patients’ telehealth visits were not enough to make up for the overall drop in total primary care visits (including in-person services) in the first two years of the pandemic.



We do not know yet the degree to which telehealth is substitutive (substitutes for in-person primary care services) or additive (creates additional, unnecessary utilization)—and the answer will vary depending on the condition being treated. When developing long-term policies, policymakers must balance the convenience of telehealth with its potential to create excess utilization and drive-up Medicare spending. If future research reveals that telehealth is additive, policymakers can create additional guardrails to protect against unnecessary use. However, if a significant share of tele-primary care is substitutive, it could create the potential for cost savings while improving clinical outcomes and quality.

Tele-primary care utilization rates are not sufficient to make determinations about telehealth substitutability, especially because they do not show the clinical context for these visits. Studies conducted during the pandemic, however, found that telehealth visits were less likely to include common screenings and assessments, such as blood pressure or cholesterol.¹⁸⁸ Nevertheless, there was broad consensus among providers BPC spoke to that patient education and management of chronic conditions could be done virtually. In conjunction, these data may indicate that tele-primary care services may not be suitable for all situations and conditions but could provide value for patients and providers in certain contexts.

Although tele-primary care utilization [declined](#) by 5% in 2021 compared with 2020, current available data do not reflect telehealth utilization in a post-pandemic world.¹⁸⁹ Policymakers and regulators will need additional data to uncover tele-primary care's impact on access, quality, equity, patient outcomes, and cost.

Tele-primary care services during the pandemic were especially critical for people with chronic conditions. Most tele-primary care visits were for Medicare beneficiaries with multiple chronic conditions in 2020 and 2021—56% were for those with five or more chronic conditions.¹⁹⁰ Patients with chronic conditions need more frequent touchpoints with health care providers. Telehealth has the potential to reduce in-person and ED visits for these individuals, thereby reducing unnecessary and costly utilization.

However, the cost savings associated with diverting care away from the ED are not well understood. Additional study is needed to know whether tele-primary care diverts care away from the ED and urgent care, whether tele-primary care can effectively substitute for in-person care, and whether an increase in access to tele-primary care services leads to cost reductions and similar or improved outcomes.

Providers' concerns about telehealth quality may be preventing the Medicare program from realizing telehealth's full potential. Some physicians chose not to use telehealth during the pandemic—20% cited concerns about the possibility of diminished care quality.¹⁹¹ Without further study, outreach, and education,

physicians may continue to question the impact of telehealth on quality of care, even though hybrid models could improve outcomes and reduce costs.

Further analysis will help answer the following questions:

- When can telehealth, in combination with in-person care, improve health care quality, clinical outcomes, and patient satisfaction?
- Where can telehealth save money for the health care system (including downstream impact)?

MedPAC should conduct a formal evaluation on the effects of tele-primary care on access, quality, cost, and outcomes and issue a report to Congress with at minimum one year of data after the end of the PHE. MedPAC should issue both an interim and a final report. The interim report would allow policymakers to craft permanent policies before extended flexibilities expire and the final report would paint a more complete picture of telehealth utilization and outcomes. The amended 2022 Consolidated Appropriations Act ([P.L. 117-103](#)) included a provision requiring MedPAC to formally evaluate telehealth utilization, program expenditures, payment policy, implications of expanded coverage, and other areas by June 2023.¹⁹² However, this report may not properly capture the state of telehealth utilization in a post-pandemic world because the PHE declaration is likely to continue into 2023. BPC recommends that MedPAC continue to conduct evaluations following the end of the PHE declaration to adequately capture what telehealth utilization could look like in the long-term.

Refine Access to Audio-Only Tele-Primary Care Services

To address growing concerns around the effectiveness of audio-only telehealth services, the administration should:

- **Implement established patient requirements for tele-primary care audio-only services.**

As described earlier in the report, BPC recommends that patients continue to be allowed to receive telehealth services at home, outside of designated health care facilities, beyond the PHE. As an additional guardrail for tele-primary care audio-only services, CMS should implement established patient requirements given quality concerns.

While coverage for audio-only services could help alleviate health inequities and access issues, some stakeholders say that unrestricted use of these services could create a two-tiered system where some have access to higher quality, face-to-face interventions and others can only access health care via phone. However, populations relying on audio-only services may not have access to care otherwise due to technological constraints. Although preliminary evidence shows that audio-only visits may be equivalent to in-person visits

for behavioral health services, there is little evidence on the quality of audio-only primary care services. Moreover, physicians may miss important visual information in an audio-only visit, especially if they are unfamiliar with a patient and his or her medical history. Others have also raised concerns that audio-only services are more susceptible to overuse and fraud. Therefore, BPC recommends that CMS only reimburse audio-only tele-primary care services within the context of an established relationship between a patient and a provider.

For the purposes of audio-only primary care services, a patient and the provider/practice can currently only establish a relationship in-person. CMS's definition says: "The billing physician or practitioner must have furnished an in-person, non-telehealth service to the beneficiary within the 6-month period before the date of the telehealth service."¹⁹³ Although CMS's established patient requirements apply to behavioral health services once the PHE expires, BPC believes they could be applied to primary care services. CMS currently dictates that patients may establish a relationship by conducting an in-person appointment with their clinician or another clinician in the practice. The agency articulates that "for purposes of deciding whether a patient is a new or established patient, or whether to bill for initial or subsequent visit, practitioners of the same specialty/subspecialty in the same group are treated as the same person." This may alleviate concerns about provider availability.

Although patients may not have access to broadband, health care providers often rely on visual observations to glean valuable information about a patient's health. In stakeholder interviews, providers expressed concern about providing care via telephone when they did not know a patient's medical history and could not assess their health status visually. Given continuity of care concerns and the need to balance access and quality, Medicare beneficiaries should be able to access audio-only services, but only if they have an established relationship with a provider or practice.

Evaluate Reimbursement for Tele-Primary Care Services Post-PHE and Draw Lessons from Current Payment Models

At the end of the public health emergency, HHS should:

- **Continue to evaluate whether telehealth reimbursement for FQHCs and RHCs is adequate to ensure they continue to use telehealth in a way that best serves vulnerable populations.**
- **Use lessons learned from current Medicare demonstrations to inform new models that incorporate virtual care services.**

Given equity concerns, CMS should review reimbursement levels for certain clinical sites serving the nation's most vulnerable populations, such as FQHCs and RHCs, to ensure adequacy. These sites serve at-risk populations who are

more likely to face barriers to accessing health care. During the pandemic, FQHCs and RHCs provided a growing share of visits via telehealth, even as overall telehealth utilization declined, indicating that telehealth is an important care delivery tool for these populations. FQHCs and RHCs, combined, [amounted](#) to the highest share of facility telehealth visits in 2020 and 2021, compared with visit rates to any other individual facility type (for codes included in the study).¹⁹⁴ This happened despite CMS not reimbursing FQHC and RHC telehealth services at parity to in-person visits during the PHE.

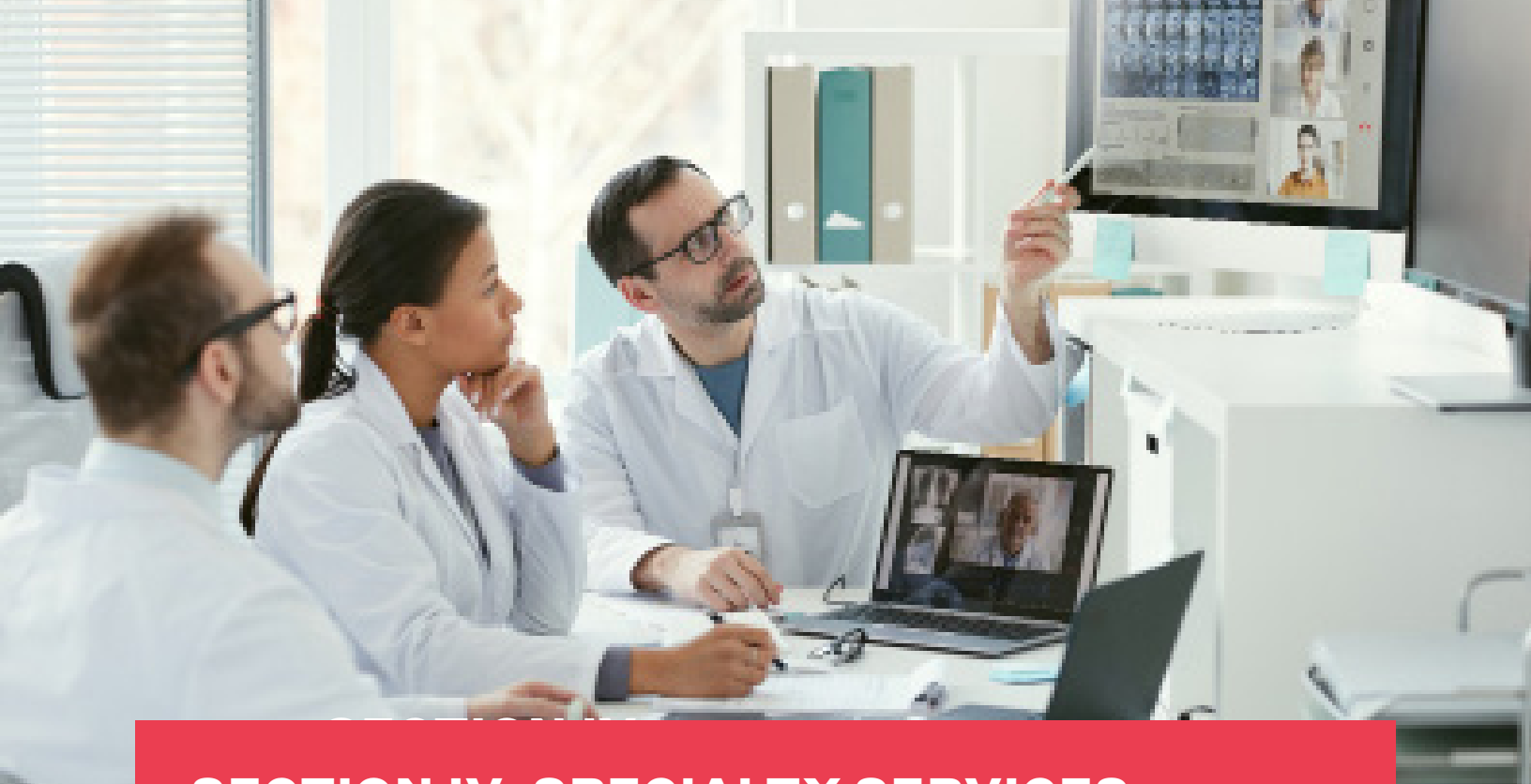
Before the pandemic, FQHCs and RHCs were only considered originating sites for telehealth services, and they were paid for hosting an interaction between a patient and a specialist at the distant site. During the PHE, these providers were given the ability to deliver telehealth services as distant site providers. FQHCs and RHCs are paid a single rate through the special payment mechanism, which is lower than an in-person visit rate. This payment rate is the average of the Physician Fee Schedule reimbursement for all services on the list of telehealth codes approved by CMS and amounts to approximately \$92 in 2021.¹⁹⁵ Primary care services are largely underpriced in the fee schedule relative to other services, and CMS should continue to evaluate whether reimbursement for these providers is adequate to ensure they continue to use telehealth in a way that best serves vulnerable populations.

There are also advantages of promoting virtual flexibilities in value-based payment models. For providers participating in value-based payment, they can invest their resources in a way that produces the best clinical and quality outcomes, and they can make decisions more seamlessly about how and when to integrate virtual services. In fact, CMS is working towards moving all traditional Medicare beneficiaries into accountable care models by 2030.¹⁹⁶

Several Medicare demonstrations allow for broad telehealth flexibility. Primary Care First is a five-year primary care initiative launched in 2019 by CMMI where provider prospective payments give the provider flexibility to meet patients' needs outside of regular office visits (e.g. telehealth, care management, patient education and outreach).¹⁹⁷ CMMI should draw lessons from this model and other advanced primary care models to inform the best way to incorporate virtual care services.

Fee-for-service reimbursement for individual digital interactions risks incentivizing volume and making it less likely the technology will be cost effective. Given these risks, CMMI should design demonstrations that support the use of digital health and evaluate the impact of telehealth use on relevant clinical, quality, and cost outcomes. While outside the scope of this report, a growing area of interest is remote patient monitoring. A recent study showed that during the pandemic, remote patient monitoring among Medicare beneficiaries increased 555%, raising concerns about potential overuse given a lack of robust evidence regarding which types of patients benefit from this service.¹⁹⁸

In 2020, the Alliance of Community Health Plans proposed a multiyear demonstration for a Medicare telehealth reimbursement model. A provider would begin in fee-for-service reimbursement for telehealth services and then shift over time to a capitated, risk-adjusted per-member/per-month payment.¹⁹⁹ This could include a capitated number of telehealth visits per beneficiary per year. Others have suggested that a similar phased approach could be applied to episode-based models, where a period of payment parity could allow HHS to evaluate how telehealth affects quality and use. That information could then be used to adjust telehealth reimbursement as part of episode spending targets.²⁰⁰



SECTION IV: SPECIALTY SERVICES

Telehealth can be a valuable tool to connect patients to specialty services that they may not have access to otherwise. However, evidence on outcomes associated with broad access to specialty services delivered via telehealth is limited—creating the need for more guardrails to ensure that care is delivered appropriately and in a way that does not further fragment care.

Refine Access to Tele-Specialty Services

To refine access to all other specialty care:

- Congress should grant waiver authority to HHS to extend access for tele-specialty services to Medicare beneficiaries for two years following the end of the PHE and require MedPAC to complete a formal evaluation of the impact on access, quality, patient outcomes, and cost.
- Congress should allow newly eligible health care providers to continue to bill for telehealth services during the two-year extension period, and HHS should evaluate the cost and quality outcomes of their services before allowing them to bill Medicare directly on a permanent basis.
- If further evaluation supports it, CMS should consider implementing established patient requirements for other tele-specialty care, except for beneficiaries living in rural and frontier areas, and for providers participating in APMs with two-sided risk.

- **CMS should limit audio-only visits for specialty services to rural and frontier areas, to non-rural beneficiaries with attested barriers to video visits, and for providers participating in APMs with two-sided risk.**
- **CMS should permanently expand asynchronous (store-and-forward) services beyond virtual check-ins and Alaska and Hawaii demonstrations for Medicare beneficiaries.**

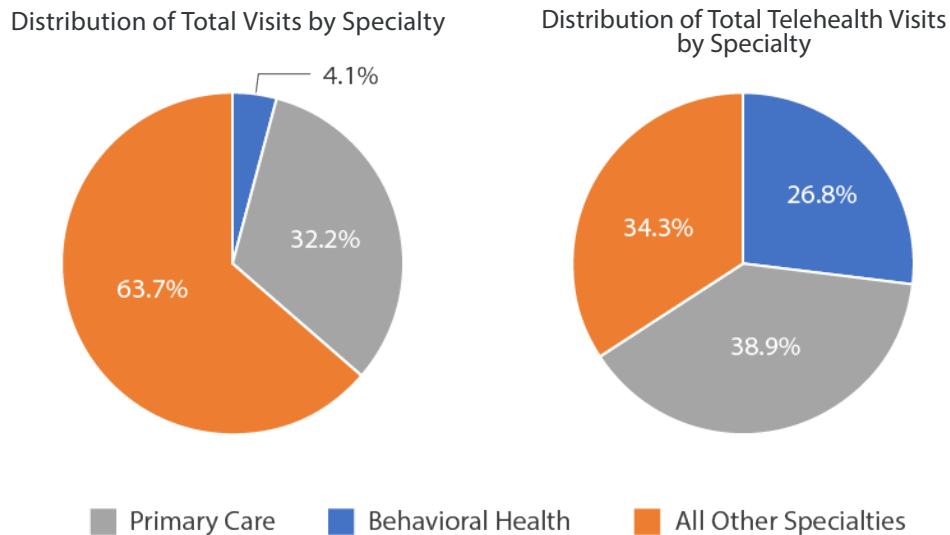
As has been emphasized throughout this report, Congress and the administration should extend most telehealth flexibilities for Medicare beneficiaries for an additional two years after the end of the PHE. Congress should also require MedPAC to complete a formal evaluation of telehealth's impact on access, quality, patient outcomes, and cost, as was outlined for the study of tele-primary care. This approach would enable beneficiaries to maintain access to tele-specialty services, while providing time for policymakers and researchers to continue to review and assess the evidence.

BPC recommends that post-PHE, policymakers consider guardrails for tele-specialty care. Given the limited evidence on specialty services delivered through telehealth and their outcomes—we do not yet know the extent to which telehealth is appropriate across all clinical contexts. This uncertainty necessitates additional evaluation, as has been articulated throughout this report, as well as guardrails to ensure that care is delivered appropriately and in a way that does not further fragment care.

Researchers should evaluate the benefits of hybrid (in-person and virtual) care models for specialty care, including for which conditions and specialties it is most effective, further evaluate full telehealth flexibilities in the context of value-based payment models, and rigorously assess the quality of audio-only care.

BPC's data [analysis](#) showed that of the codes we included in our study, specialty visits (excluding behavioral health visits) made up approximately 64% of total Medicare visits for the first three quarters of 2021; yet they represented only 34% of total telehealth visits during the same period (see Figure 7). After primary care and behavioral health, telehealth visits for cardiology services were the largest in order of magnitude.²⁰¹

Figure 7: Distribution of Total Medicare Visits and Total Telehealth Visits by Specialty, 2021²⁰²



Note: Total visits refers to only those visit codes included in this study and not all Medicare visits.

BPC recommends that Congress extend the ability of health care professionals who were newly allowed to furnish telehealth services during the PHE to bill for telehealth services for Medicare beneficiaries during the two-year extension period post PHE. (Examples include physical therapists, occupational therapists, speech-language pathologists, and audiologists.) HHS should evaluate the cost and quality outcomes of these newly eligible health professionals before allowing them to bill Medicare directly on a permanent basis. It will be important to evaluate the impact of telehealth services delivered by these providers either as part of hybrid in-person/virtual care models or exclusively telehealth models of care. Permanently expanding eligibility of these providers to deliver telehealth services will require new legislation.

Except for rural and frontier areas, and if further evaluation supports it, CMS could consider implementing established patient requirements for most tele-specialty care services. One option is for CMS to require that the treating provider's practice has seen the patient in-person within six months of a telehealth service for specialty care. A six-month look-back would align with the current established patient requirements CMS has outlined for behavioral health services. Aligning the definition of what it means to be an established patient across all service types (primary care, behavioral health, and other specialty care) is critical for minimizing confusion among patients and providers regarding the telehealth benefit.

Given that telehealth has long been a tool to improve access to care in rural America, any established patient requirements for tele-specialty care services should not apply to individuals living in rural areas. Rural communities persistently face health care worker shortages and have far fewer providers per

capita than urban areas, particularly when it comes to specialists. Only 11% of physicians practice in rural areas, even though 20% of the U.S. population lives there.²⁰³

As mentioned previously in the report, specialists in APMs with two-sided risk should also have maximum flexibility to use telehealth with their patients—including the flexibility to use audio-only visits and establish relationships with new patients virtually. Medicare already allows flexibility for providers participating in APMs to bill for telehealth services, and BPC recommends that CMMI allow current telehealth flexibilities in all new models where providers are participating in two-sided risk. In other words, even with the above guardrails in place, specialists would still be able to establish a virtual-first relationship with a patient if they participate in a two-sided risk APM or if they are providing care to a rural resident. Enhanced telehealth flexibilities for providers participating in certain APMs may serve as a carrot to encourage additional providers to transition to value-based care. This would also align with CMS's goal to shift Medicare beneficiaries to APMs with accountability for quality and total cost of care.

Additionally, CMS should limit audio-only visits for specialty services to rural areas; to beneficiaries living in non-rural areas with attested access barriers to video visits; and for providers participating in APMs (tele-behavioral health is considered separately from all other specialty care throughout this report). Patients should have an encounter (video or in-person) with the provider or a provider within the same practice within six months before the audio-only visit. CMS could also consider allowing a primary care provider to refer a patient directly to a specialist for audio-only care.

Lastly, CMS should permanently expand asynchronous (or store-and-forward) telehealth services beyond virtual check-ins and Alaska and Hawaii demonstrations for Medicare beneficiaries. Store-and-forward telehealth is the electronic transmission of medical information to a practitioner at a distant site, usually a specialist, who uses the information outside of a live interaction with a patient. For example, photographs of a patient's skin lesion can be sent to a specialist to review the medical case without the patient being present. In many states, telehealth services must occur in real time, automatically excluding store-and-forward technology. However, asynchronous telehealth services are particularly well suited for consultation with a specialist and for reviewing imaging and other diagnostic studies. Twenty-two state Medicaid programs currently reimburse for store-and-forward services.²⁰⁴ Medicare allows store-and-forward through telehealth demonstration projects in Alaska and Hawaii and, as of 2019, for established patients through virtual check-ins.²⁰⁵ BPC recommends that all individuals, especially for those living in rural areas, be able to access asynchronous telehealth services outside of an established patient relationship.

Conclusion

Broad telehealth flexibilities afforded during the PHE substantially improved access to care, convenience, user experience, and utility of virtual care. What was less than 1% of all care before the pandemic, virtual care exploded in recent years—an approximately thirty-eightfold increase in utilization.²⁰⁶ This growth presents policymakers with both new opportunities and challenges.

It is widely expected that telehealth will remain a permanent fixture in care delivery and continue to represent a larger share of care than before the pandemic. Most providers plan to continue delivering virtual services after the PHE, and most private payers maintain their own suite of virtual care options. However, the more complex the requirements on telehealth become, especially as blanket waivers expire, the more challenging it will be for providers to deliver telehealth services.

BPC's telehealth recommendations are evidence-based, viable solutions to help guide policymakers forward after the PHE ends. Recommendations are derived from interviews with health policy experts, national organizations, providers, payers, technology experts, consumer representatives, and academics, and they build on the evidence that has accumulated via claims data analyses, consumer polls, and the existing academic literature.

The recommendations address immediate policy questions of whether certain flexibilities should remain permanently available to Medicare beneficiaries, including what types of services should remain accessible via telehealth, who would benefit from access to telehealth, by what modality, and how they should be reimbursed. BPC's work offers a necessary step forward to bridge pandemic-related telehealth policies with what is already becoming an integral part of health care delivery in the United States.

Appendix

BPC's Recommendations for Established Patient and In-Person Visits, by Telehealth Modality Across Service Type for post PHE Extension

	Behavioral Health	Primary Care	Other Specialty
Two-way video	No established patient or in-person visit requirements recommended.	No established patient or in-person visit requirements recommended.	<p>If further evaluation supports it, policymakers could consider allowing two-way video services only for established patients (this would not apply to beneficiaries living in rural areas or those seeing providers participating in APMs).</p> <p>No ongoing in-person visit requirements recommended.</p>
Audio-only	<p>Must be an established patient to access audio-only services. Patient can establish the relationship via video or in-person.</p> <p>No ongoing in-person visit requirements recommended.</p>	<p>Must be an established patient to access audio-only services. Patients must have an encounter in-person to establish the relationship.</p> <p>No ongoing in-person visit requirements recommended.</p>	<p>Must be an established patient to access audio-only services. Patients must have an encounter (video or in-person) to establish the relationship.</p> <p>Additionally, beneficiary must live in a rural area, have attested access barriers to video visits, or see a provider participating in APMs.</p> <p>No ongoing in-person visit requirements recommended.</p>

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