**MedPac Summary**

**Main Takeaway:**

Telehealth has been crucial for getting beneficiaries the care they need during the pandemic. While the effects of the pandemic have yet to be seen in full, it has shown that telehealth can successfully substitute in-person care and expand access to health care across a variety of sectors. More data is needed before a final determination can be made on whether to make telehealth coverage permanent, but MedPac believes it should be continued in some form for the next few years after the pandemic is over.

**Pg. 7-8, Introduction**

* Health care inequities have led a higher rate of COVID-19 deaths in marginalized communities compared to white communities (ex. Hispanic Americans’ death rate from COVID is 54% higher than white Americans’)
* Medicare is uniquely impacted by COVID since older Americans are more likely to die from COVID than younger Americans
* Nearly half a million excess deaths (2/3 from COVID, others from noninfectious diseases that went untreated or unrecognized)
* Nonwhite people are disproportionately represented in frontline industries, exposing them a higher COVID risk. They are also more likely to put off urgent care.
* The share of Medicare beneficiaries who delayed or forwent care was not substantially higher than previous years, but the pandemic was an frequently-cited reason why.
* Beneficiaries are more likely to delay routine care than emergency care.
* Telehealth took the place of many appointments, but other procedures that require in-person care (ex. colonoscopies and blood work) were delayed.

**Chapter 2, pg. 37-48**

* FFS = fee-for-service
* How they determine payment updates:
	+ Assess adequacy of Medicare payments for providers in current year (2021)
	+ Beneficiaries’ access to care
	+ Quality of care
	+ Providers’ access to capital
	+ How Medicare payments compare to providers’ costs
	+ Will providers’ costs change in the next year? (i.e. 2022)
	+ What, if any, update is needed?
* Temporary shocks are best addressed via targeted temporary funding 🡪 COVID falls into this category
* Providers were hit financially in spring 2020 due to the sharp decline in demand 🡪 Congress and CMS allocated federal grants to providers (example of not-so-targeted temporary funding)
* While they expect COVID to be a temporary issue for health care financing, they acknowledge it may have an impact on cost structures through 2022 for some sectors.
* 9 recommended FFS sectors:
	+ Acute care hospitals
	+ Physicians and other health professional services
	+ Ambulatory surgical centers
	+ Outpatient dialysis facilities
	+ Skilled nursing facilities
	+ Home health agencies
	+ Inpatient rehabilitation facilities
	+ Long-term care hospitals
	+ Hospices
* The most recent complete data are generally from 2019 (what payment calculations will be based on).
* Access to care is indicative of providers’ willingness to participate in the Medicare system (i.e. if there is low access to medical care, this may be because Medicare payments to providers are too low to incentivize involvement)
* Access can be impacted by excess providers of a given service, dual coverage from private insurers, and changes in technology that impact providers’ capacity (i.e. surgeries becoming less invasive)
* When payment rates for discretionary services are reduced, providers may attempt to make up for lost revenue by increasing volume.
* At the start of the pandemic, the decline in physician visits was offset by rise in telehealth appointments. By June, telehealth + regular appointments nearly equaled the volume of care in previous years.
* There is no direct correlation between Medicare payments and quality of care.

**Chapter 4, pg. 95-124**

* PFS = physician fee schedule
* E&M = evaluation & management office visits
* PHE = public health emergency
* Despite pandemic, one study showed no statistical increase in wait times for appointments or in the number of patients who had to forego care due to poor access. This is likely because telehealth increased access during the pandemic.
* 15% of beneficiaries reported having a video visit in the past year; 37% reported having an audio-only visit
* There is an increase in number of provider encounters per beneficiary.
* It is estimated that in 2018, 22-36% of beneficiaries in traditional Medicare received at least one low-value service 🡪 Medicare spending for these services ranged from $2.4-6.9 billion
* Before the pandemic, Medicare only covered telehealth that was in a providers’ office or rural area. When restrictions were loosened on telehealth, providers expanded their use of it.
* Telehealth comprised 26% of allowed charges for all E&M visits in April 2020, but only 16% of allowed charges for all PFS services.
* The Commission does not recommend permanent policy changes due to the PHE yet and believes temporary, targeted policies to affected sectors are a better solution for now.
* Adequate access to care was maintained during the pandemic (about equal rates as previous years)
* Privately insured patients were more likely to have telehealth calls with video than they were to only have audio calls.
* “Medicare beneficiaries’ satisfaction with these visits was slightly higher than satisfaction with overall health care: 91 percent of Medicare beneficiaries were satisfied with their video visits and 92 percent were satisfied with their phone visits, while 88 percent were satisfied with their overall health care.” (103)
* Many beneficiaries and providers like telehealth in theory but have concerns with it in practice (i.e. loss of in-person contact and tech issues are common complaints).
* Medicare and privately insured beneficiaries are all reporting fewer encounters with primary care providers, indicating that there may be systematic changes in the delivery of this care (i.e. potentially more work being done in this field now by PAs).
* “[Clinician] revenue was 45 percent lower in March 2020 than in March 2019 (FAIR Health 2020). Revenues began to recover in May and were higher than the prior year starting in July. By October (the most recent month of data available), revenues were 20 percent higher than the prior year. These results suggest that patients’ higher than usual demand for services in the summer and fall of 2020 helped offset the temporary revenue drop experienced by clinicians during the first few months of the pandemic.” (116)
* Private insurers pay higher rates to clinicians generally. This is not a major issue now, but “eventually the difference between private insurance rates and Medicare rates could grow so large that some clinicians would have an incentive to focus primarily on patients with private insurance instead of Medicare patients.” (117)
* “For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.” (122)

**Chapter 14, pg. 457-469**

* Telehealth affects a lot of things, but specifically impacts PFS.
* Pre-pandemic, telehealth used to be compensated at a lower rate.
* Some of the new coverage also applies to audio-only calls.
* During PHE, clinicians may reduce or waive beneficiaries’ cost-sharing obligations for telehealth services.
* These measures are expected to remain in place for the duration of the PHE.
* Keeping it permanently should be based on principles of access, quality, and cost.
* No evidence now to suggest telehealth + in-person care combo affects quality or cost of Medicare (mainly because enough research hasn’t been done into this question)
* Report presents a policy option where telehealth expansions can continue for 1-2 years after the PHE:
	+ Medicare should cover telehealth for specified services regardless of location
	+ Should cover select telehealth services in addition to services covered before PHE if there is potential clinical benefit
	+ Should cover audio only too if there is potential clinical benefit
* After PHE, go back to fee schedule facility rate (lower) for telehealth and collect data on service cost.
* “During the first 6 months of 2020, 10.3 million beneficiaries in FFS Medicare (32 percent of the total) received at least one telehealth service, compared with 134,000 beneficiaries during the first 6 months of 2019.” (462)
* There is a concern that telehealth will supplement rather than substitute care, leading to higher expenditures. There are also fraud concerns.
* Clinicians in FFS Medicare have less flexibility to bill for telehealth than clinicians in advanced alternative payment models.
* Policymakers should continue some aspects of telehealth coverage after PHE to gather more data on its impact/usefulness
* CMS lists 140+ PFS telehealth services that Medicare will cover (9 will be permanently covered after PHE)
* Allowing audio only treatment when appropriate increases access and equity for those who don’t have video capabilities. (Sometimes telehealth appointments become audio only anyway due to tech issues)
* “In 2021, Medicare pays the originating site a flat fee of $27 per service. However, CMS does not pay an originating site fee if the beneficiary is not located at an originating site (e.g., if the beneficiary is at home). Medicare pays the clinician at the distant site a PFS payment based on the type of service provided[.]” (466)
* Clinicians billing for telehealth raises questions about the role of direct-to-consumer telehealth vendors in Medicare 🡪 CMS should collect cost information to learn how to appropriately bill for this care
* They expect long run marginal cost of telehealth services to be lower than in-person services 🡪 should not continue to pay equal rates to in-office care after PHE
* CMS criteria for revising list of allowable telehealth services
	+ 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list.
	+ 2: Services that are not similar to those on the current Medicare telehealth services list
	+ 3: Services that were added during the public health emergency (468)