



Testimony

Before the Subcommittee on Agriculture,
Energy, and Trade and Subcommittee on
Health and Technology, Committee on Small
Business, House of Representatives

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TELEHEALTH

Use in Medicare and Medicaid

Statement of A. Nicole Clowers, Managing Director,
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GAO Highlights

Highlights of [GAO-17-760T](#), a testimony before the Subcommittee on Agriculture, Energy, and Trade and Subcommittee on Health and Technology, Committee on Small Business, U.S. House of Representatives.

Why GAO Did This Study

Telehealth can provide an alternative to health care provided in person at a physician's office, particularly for patients who cannot easily travel long distances for care. Medicare pays for some telehealth services that are subject to statutory and regulatory requirements, such as requiring the patient be present at an originating site like a rural health clinic.

This testimony discusses (1) the extent to which telehealth is used by Medicare and Medicaid to provide health care services; (2) factors selected associations representing providers, patients, and payers reported as affecting the use of telehealth in Medicare; and (3) how emerging payment and delivery models could affect the potential use of telehealth in Medicare.

This testimony is based on GAO's April 2017 report ([GAO-17-365](#)). For that report, GAO reviewed agency documents and regulations and interviewed Medicare agency officials and Medicaid officials from six states, selected based on multiple factors, including rural population. GAO also selected specialty associations with expertise and interest in telehealth—five provider, two patient, and one payer association—based on a review of documents and literature and through background interviews. GAO interviewed representatives from each of the associations and also collected information from the provider and patient associations through a data collection instrument. In addition, GAO reviewed agency documents describing and evaluating the models and demonstrations that support alternative approaches to health care payment and delivery.

View [GAO-17-760T](#). For more information, contact A. Nicole Clowers at (202) 512-7114 or clowersa@gao.gov.

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What GAO Found

Available analysis GAO reviewed shows that Medicare providers used telehealth services (providing clinical care remotely by 2-way video) for a small proportion of beneficiaries and relatively few services in calendar year 2014. Specifically, an analysis of Medicare claims data by the Medicare Payment Advisory Commission shows that about 68,000 Medicare beneficiaries—0.2 percent of Medicare Part B fee-for-service beneficiaries—accessed services using telehealth. The most common telehealth visits in calendar year 2014 were for evaluation and management services (66 percent), followed by psychiatric visits (19 percent). In Medicaid, the use of telehealth varies by state. Individual states have the option to determine whether to cover telehealth, what types of telehealth services to cover, and which types of providers can receive reimbursement for telehealth services, among other things. In the six states GAO reviewed, officials from states that were generally more rural than urban said they used telehealth more frequently than officials from more urban states.

Selected provider, patient, and payer associations GAO interviewed reported that telehealth may improve care for Medicare beneficiaries, but they also cited coverage and payment restrictions as barriers to the use of telehealth in Medicare.

- Officials from the selected associations reported several factors that encourage the use of telehealth in Medicare, including the potential to improve or maintain quality of care in Medicare, alleviate provider shortages, and increase convenience to patients. For example, officials from one provider association noted that provider and regional medical specialty shortages can be addressed through telehealth, potentially increasing productivity and ensuring on-time scheduling of appointments.
- Officials from the selected associations also reported several potential barriers to the use of telehealth in Medicare, including payment, coverage restrictions, and infrastructure requirements. For example, officials from one provider association and both of the selected patient associations described access to sufficiently reliable broadband internet service as a barrier to telehealth use.

The Centers for Medicare & Medicaid Services (CMS), which administers Medicare, has various efforts underway that have the potential to expand the use of telehealth in Medicare. As of April 2017, CMS was supporting eight such models and demonstrations. For example, CMS's Frontier Community Health Integration Project Demonstration aims to develop and test new models of integrated health care in sparsely populated rural counties. Under the demonstration, CMS allows participating providers to receive cost-based payments for telehealth when their location serves as the originating site, rather than the approximately \$25 fixed fee that CMS otherwise pays originating sites.

Chairmen Blum and Radewagen, Ranking Members Schneider and Lawson, and Members of the Subcommittees:

I am pleased to be here today to discuss the use of telehealth in Medicare and Medicaid.¹ For certain individuals, such as those who live in remote areas or who cannot easily travel long distances, access to health care services can be challenging. Telehealth can provide an alternative to health care provided in person at a physician's office by providing clinical care remotely through two-way video for services such as psychotherapy or the evaluation and management of conditions. Medicare pays for some telehealth services subject to statutory and regulatory requirements, such as the requirement that the patient be present at a site such as a rural health clinic. Telehealth services in Medicaid may vary from those provided in Medicare, as individual states determine whether to cover telehealth services and any requirements for such coverage. At the federal level, the Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), administers Medicare and is responsible for overseeing state Medicaid programs.

My testimony today summarizes the findings from our April 2017 report on telehealth.² Accordingly, my testimony addresses

- (1) the extent to which telehealth is used by Medicare and Medicaid to provide health care services;
- (2) factors that selected associations representing providers, patients, and payers reported as affecting the use of telehealth in Medicare; and
- (3) how emerging payment and delivery models could affect the potential use of telehealth in Medicare.

To conduct the work upon which this statement is based, we reviewed agency documents and regulations and interviewed Medicare agency officials and state Medicaid officials from six selected states—Connecticut, Illinois, Kansas, Mississippi, Montana, and Oregon—which

¹For this testimony, we define telehealth as clinical services that are provided remotely via telecommunications technologies.

²GAO, *Health Care: Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs*, [GAO-17-365](#) (Washington, D.C.: April 14, 2017).

we selected based on variation in geography, physical size, percentage of rural population, and other factors related to coverage and reimbursement for health care services. We also obtained documents from and interviewed association officials from general and medical specialty associations with expertise and interest in telehealth—five provider, two patient, and one payer association—which we selected based on a review of relevant documents and literature and through background interviews. We also collected information from the provider and patient associations through a data collection instrument. In addition, we reviewed CMS documents describing and evaluating models and demonstrations that support alternative approaches to health care payment and delivery. More detailed information on our objectives, scope, and methodology for that work can be found in the issued report. We conducted the work on which this testimony is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Use of Telehealth in Medicare and Medicaid

As we reported in April 2017, available data from the Medicare Payment Advisory Commission (MedPAC) show that Medicare providers used telehealth services for a small proportion of beneficiaries and relatively few services in calendar year 2014, the latest data available at the time of our audit work. In Medicaid, the use of telehealth varies by state.

Medicare

Medicare pays for certain telehealth services, including consultations, office visits, and office psychiatry services.³ While telehealth visits with providers are conducted from a separate site, Medicare requires that the patient be physically present at a medical facility such as a hospital, rural health clinic, or skilled nursing facility—referred to as the originating site—

³Medicare payment for telehealth services in Medicare fee-for-service is limited to those on CMS's approved list of telehealth services. Plans within Medicare Advantage—the Medicare managed care program—must cover the same telehealth services as those provided through fee-for-service, though Medicare Advantage plans can provide additional telehealth benefits not on CMS's approved list to their beneficiaries by using rebate dollars or charging beneficiaries a supplemental premium. Plans must receive CMS approval in order to provide the additional telehealth benefits.

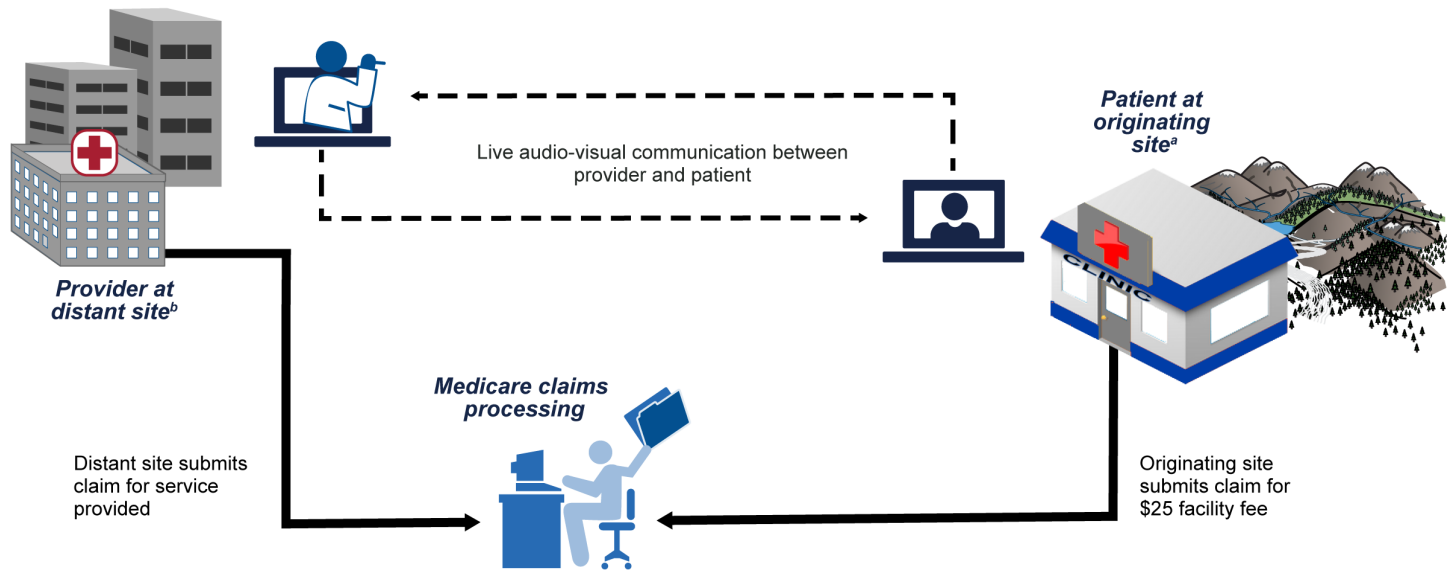
during the telehealth service.⁴ Eligible providers who are furnishing Medicare telehealth services are located at a separate site, known as the distant site, and these providers submit claims in the service area where their distant site is located.⁵ The originating site is paid a facility fee—about \$25 in calendar year 2017—under the Medicare Physician Fee Schedule for each telehealth service, and the distant site provider is paid the same rate for services delivered via telehealth as they would be paid for the in-person service, as required by statute.⁶ (See fig. 1.)

⁴By statute, originating sites are limited to those located in rural health professional shortage areas, counties not included in a metropolitan statistical area, and sites participating in a federal telehealth demonstration project (referred to as telemedicine demonstration projects in statute) approved by or receiving funding from the Secretary of Health and Human Services as of December 31, 2000. Eligible originating sites are a physician or provider office, a critical access hospital, a rural health clinic, a federally qualified health center, a hospital, a hospital-based or critical access hospital-based renal dialysis center or satellites, a skilled nursing facility, and a community mental health center. 42 U.S.C. § 1395m(m).

⁵Eligible telehealth providers in Medicare are physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, nurse-midwives, clinical social workers, clinical psychologists, and registered dietitians or nutrition professionals.

⁶Medicare pays for physician and other health professional services based on a list of services and their payment rates, called the Physician Fee Schedule.

Figure 1: Example of Telehealth Use in Medicare



Source: GAO analysis of Medicare statute and regulations. | GAO-17-760T

^aMedicare requires that the patient be physically present at a medical facility—referred to as the originating site—such as a hospital, rural health clinic, or skilled nursing facility during the telehealth service.

^bEligible providers who are furnishing Medicare telehealth services are located at a separate site, known as the distant site.

In April 2017 we reported that available calendar year 2014 data show that Medicare providers used telehealth services for a small proportion of beneficiaries and relatively few services. An analysis of Medicare claims data by MedPAC shows that about 68,000 Medicare beneficiaries—0.2 percent of Medicare Part B fee-for-service beneficiaries—accessed services using telehealth.⁷ According to MedPAC, beneficiaries accessing telehealth averaged about three telehealth visits per person per year in calendar year 2014, and Medicare spent an average of \$182 per beneficiary, for a total of about \$14 million. MedPAC’s analysis shows that 10 states accounted for 42 percent of all Medicare telehealth visits, with South Dakota, followed by Iowa and North Dakota, accounting for the highest use—more than 20 telehealth services were provided per 1,000

⁷See Medicare Payment Advisory Commission, *Report to the Congress: Medicare and the Health Care Delivery System*, (Washington, D.C.: June 15, 2016), 229-260. Part B services include physician and outpatient hospital services.

fee-for-service beneficiaries.⁸ The most common telehealth visits in calendar year 2014 were for evaluation and management services (66 percent), followed by psychiatric visits (19 percent). MedPAC reported that physicians and nurse practitioners were the most common providers participating in telehealth visits in calendar year 2014 and, of all providers, behavioral health clinicians, including psychiatrists, made up 62 percent of providers at distant sites.

Medicaid

In our April 2017 report we found that CMS does not limit the use of telehealth in Medicaid; therefore, individual states have the option to determine whether to cover telehealth, which types of telehealth services to cover, and which types of providers can receive reimbursement for telehealth services, among other things. We interviewed Medicaid officials from six selected states and among these officials, the ones from states that were generally more rural than urban said they used telehealth more frequently than officials from more urban states. For example,

- Montana officials told us they have used telehealth as a tool to help patients see both in-state and out-of-state specialists remotely, as there is limited access to specialists in the state. According to state officials, Montana's Medicaid spending on telehealth increased from the state's fiscal years 2013 through 2015. Specifically, according to officials, Montana's Medicaid program spent about \$132,194 for 1,841 distant site claims related to telehealth in fiscal year 2013, and this amount increased to about \$284,675 for 3,218 such claims provided in fiscal year 2015.
- In contrast, officials from Illinois, which contains more urban areas, told us that telehealth represented a very small portion of the state's overall Medicaid budget and was used primarily to provide psychiatric services. According to state officials, less than \$500,000 of Illinois' \$20 billion in Medicaid spending in state fiscal year 2015 was for telehealth.

⁸The other seven states are—in rank order of use of telehealth per 1,000 beneficiaries—Wyoming, Nebraska, Minnesota, Missouri, Montana, Texas, and Oklahoma.

Selected Associations Reported That Telehealth May Improve Care for Medicare Beneficiaries but Cited Coverage and Payment Restrictions as Barriers

Our April 2017 report found that officials from selected provider, patient, and payer associations reported several factors that encourage the use of telehealth in Medicare, including the potential to improve or maintain quality of care in Medicare, alleviate provider shortages, and increase convenience to patients. For example, officials from one provider association noted that provider and regional medical specialty shortages can be addressed through telehealth, potentially increasing productivity and ensuring on-time scheduling of appointments. Officials from another provider association reported that telehealth can increase convenience by shortening or eliminating travel times—which may lead to better adherence to recommended treatments and to patient satisfaction.

Officials from the selected provider, patient, and payer associations also reported several potential barriers to the use of telehealth in Medicare, including payment and coverage restrictions. For example, officials from one provider association reported that Medicare’s telehealth policies for payment and coverage—such as those restrictions that limit the geographic and practice settings in which beneficiaries may receive telehealth services—are more restrictive than the policies of other health care payers. Additionally, officials from the selected associations reported infrastructure requirements as another barrier to the use of telehealth in Medicare. For example, officials from one provider association and both of the patient associations described access to sufficiently reliable broadband internet service as a barrier to telehealth use.

CMS Has Various Efforts Underway That Have the Potential to Expand the Use of Telehealth in Medicare

Our report found that as of April 2017, CMS was supporting eight models and demonstrations that have the potential to expand the use of telehealth in Medicare. In these models and demonstrations, CMS has waived certain Medicare telehealth requirements or restrictions, such as requirements for the locations and facility types where beneficiaries can receive telehealth services. For example, the waivers allow beneficiaries receiving care under the models or demonstrations to access telehealth in urban areas or from their homes.

In another example, CMS is supporting a demonstration that could increase the amount a facility is paid when it serves as the originating site. CMS’s Frontier Community Health Integration Project Demonstration aims to develop and test new models of integrated health care in sparsely populated rural counties. Under the demonstration, CMS allows participating providers to receive cost-based payments for telehealth

when their location serves as the originating site, rather than the approximately \$25 fixed fee that CMS otherwise pays originating sites.⁹ CMS officials told us that as of January 2017, they did not have data on the utilization of the originating site facility fee waiver, as the demonstration had only been operational for a few months.

Chairmen Blum and Radewagen, Ranking Members Schneider and Lawson, and Members of the Subcommittees, I would be pleased to answer any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff members have any questions concerning this testimony, please contact me at (202) 512-7114 or clowersa@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other individuals who made key contributions to the statement include Carolyn Yocom (Director), Karen Doran (Assistant Director), Sarah Resavy (Analyst-in-Charge), Krister Friday, and Helen Sauer. Staff who made key contributions to the report upon which this statement is based are identified in that report.

⁹The Frontier Community Health Integration Project Demonstration had 10 rural health care participants, and of those, 8 had telehealth as a demonstration intervention tool.

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