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CHARTING A PAYMENT MODEL FOR TELEHEALTH SERVICES

Statement of
Robert A. Berenson, MD*
Institute Fellow, Urban Institute

before the
Committee on Finance,
United States Senate

COVID-19 HEALTH CARE FLEXIBILITIES: PERSPECTIVES, EXPERIENCES, AND LESSONS LEARNED

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500 L'Enfant Plaza SW
Washington DC 20024
urban.org

Chairman Wyden, Ranking Member Crapo, and members of the Committee,

Telehealth offers the promise of an important disruptive innovation in health care delivery. With broad adoption, the approach could simultaneously (1) increase access to care for the American public, (2) raise the quality of that care, and (3) substantially reduce spending growth. However, decisions on how to pay for expanded use of telehealth—decisions that need to be made in the near future—will determine whether that promise is achieved or, alternatively, whether telehealth adoption will raise spending substantially without corresponding benefits to patients or society.

I have spent a good part of my professional career, first as a practicing, general internist in a Washington, DC, group practice; then as a government official in charge of Medicare payment policy at the Centers for Medicare & Medicaid Services (CMS) in the Clinton administration; and for nearly 20 years as a policy researcher at the Urban Institute, exploring better ways of compensating physicians and other health professionals. (The views expressed here are my own and should not be attributed to the Urban Institute, its trustees, or its funders.) I have focused both on making improvements to the predominant fee schedule method of paying practitioners and on seeking workable payment alternatives to fee-for-service. I have also worked on these payment method issues as vice chair of the Medicare Payment Advisory Commission, better known as MedPAC, and more recently as an initial member of the Physician-Focused Payment Model Technical Advisory Committee, or PTAC, which was established under the Medicare Access and CHIP Reauthorization Act of 2015, or MACRA.

Payment reform has not been easy or particularly successful. Over the past 40 years, "alternative payment models" (APMs) have come and gone as clinicians and hospital providers have continued to battle more for their share of the fee-for-service pie rather than embrace alternatives that in the long run would enhance their own practice environment and sense of professionalism, provide economic stability to practices, and better serve their patients.

Although I am sure that with so many other issues to address following the COVID-19 pandemic, there is temptation to simply ratify as permanent what were intended to be temporary policies during this public health emergency. But Congress needs to recognize that it has a unique (though maybe short-lived) opportunity to act decisively to move away from nearly complete dependence on the Medicare Physician Fee Schedule (MPFS) to more successful, alternative payment approaches that will open the door to further APM development and adoption. In my view, making permanent the temporary public health emergency work-arounds could be a years-long setback to the compelling need for fundamental provider payment reform for Medicare and, because Medicare typically establishes the model for other payers, the entire health care system.

The Committee should understand that over the past decade as public policy has encouraged the development of so-called "value-based payment," I have been something of a contrarian, pointing out that all payment methods have strengths and weaknesses, including fee-for-service. Accordingly, I argue that the legacy payment models (for physicians, the MPFS) need attention to improve value and to better complement proposed APMs. I have also argued that many proposed APMs, although conceptually compelling, are operationally challenged if not impossible, yet they consume a lot of what economists call "opportunity costs." The result is that I sometimes defend the MPFS and point to recent improvements that have clearly added to the value produced by the MPFS (i.e., that improve access and quality at an

acceptable cost). But as I will try to make clear in this testimony, fee-for-service is a particularly inappropriate payment method for most telehealth services.

My interest in finding a payment method appropriate for what we are calling virtual care (i.e., not in person, using a growing range of communication technologies) is not new. I co-authored a paper in 2003 commenting on the Chronic Care Model, which had been recently developed by Edward Wagner and colleagues at the University of Washington.[1] Besides advocating for other innovative approaches to caring for the increasing number of individuals living with one or more chronic condition, the Wagner Model called for robust communications with patients outside of the occasional in-office visit (largely by telephone at the time). In the paper, I explained why payment for what should be high-frequency communications should not be through fee schedules; instead I called for telehealth payment primarily through per person per month (PPPM) payments. In essence, these would be telehealth accounts that would provide practices a lump sum that patients spend down to support virtual care. It is fair to say that that paper was thoroughly ignored. However, the urgency and interest in finding an alternative to fee schedule payments for telehealth has now increased substantially. In this testimony I will expand on that perspective, laying out the main barriers to fee schedule payment for telehealth services and suggesting alternatives.

Last year, CMS acted with decisive speed to provide a safety net for practices and ongoing access for patients during the public health emergency. CMS (1) introduced flexibility in the requirements for a qualifying telehealth video visit by permitting the patient's home (rather than only a medical facility) to be an accepted telehealth originating site; (2) reversed a long-standing policy, now designating phone calls as short as five minutes as a reimbursable service; (3) softened security and privacy requirements to permit usage of a broad range of communication devices and methods; and as I will discuss in more detail below, (4) raised fees substantially, in the process ignoring the resource-based relative value scale approach that the organization has followed since 1992, however imperfectly. The public health emergency modifications also expanded the range of clinicians, such as physical therapists, eligible to bill telehealth services.

I will identify three major reasons why maintaining most of these rule flexibilities and increased payments should not be maintained over the long term. Adele Shartzer (an Urban Institute colleague) and I outlined these concerns in a recent paper in *JAMA Forum*.[2]

1. Administrative Complexity

Fee schedules can function reasonably well when code descriptions are concise and specific, thereby producing reliable and accurate coding. For example, there are about 20 different payment codes for colonoscopies, with each one detailing whether there was a polyp removed, a biopsy taken, or some other distinctive feature of the procedure. Colonoscopies represent a clearly defined procedure. Operationally, it is easy to bill for and receive fee schedule payment for a colonoscopy. Most procedures, tests, and

[1] Berenson, RA and Horvath J. Confronting the Barriers to Chronic Care Management in Medicare Health Affairs, 22, Suppl 1 (2003): W3-1- W3-14.

[2] Robert Berenson and Adele Shartzer, "The Mismatch of Telehealth and Fee-for-Service Payment," *JAMA Health Forum* 1, no. 10 (2020): e201183.

imagings lend themselves operationally to payment by fee schedule. But codes for telehealth services are not concise; indeed, CMS telehealth codes attempt to delineate the specific communication technology employed, the patient's location during the communication, which party initiated the service, the duration of the virtual encounter, the time interval from prior and subsequent office visits, the frequency of allowed billing for the service, and other characteristics specific to the particular telehealth services. Importantly, these coding parameters were established for payment purposes alone: they do not provide useful clinical distinctions. Given rapidly evolving technological capabilities, telehealth codes will quickly become outdated. The tangle of telehealth codes (now numbering about 250 and counting in the MPFS), combined with lots of code requirements, will lead to fraud in some cases, but also more commonly to "gaming behavior" by provider practices. For example, if a phone call needs to last at least five minutes to qualify for payment, how will Medicare ferret out four-minute calls that were billed (many of which will be as clinically important as calls lasting a minute longer). Will the agency require use of timing devices on phones?

Especially if overly generous payments are made through pay parity for telehealth visits and phone calls, CMS will feel compelled to impose additional burdensome (and ultimately ineffective) documentation requirements as these telehealth services proliferate. In short, following the COVID-19 pandemic, using the standard MPFS to pay for telehealth services would likely produce a quagmire of confusion, inadvertent or intentional miscoding, and lots of clinician and patient complaints about burden and counterproductive rules.

2. Billing Costs in Relation to Payment Levels

For reasons that practices and hospitals know well but policymakers rarely acknowledge, fee-for-service payments can generate high billing costs relative to the payment sought and received. The result is that it is imprudent to pay for high-frequency, low-payment services by fee schedule, at least when the low-priced service is the only service billed rather than one line on a larger claim. A recent study from an academic health center found that the cost for billing and related documentation activities for an office visit was $20.49, including 13 minutes of work for various individuals, including clinicians.[3] There is no obvious reason why billing and documentation costs for submitting telehealth services would be much less than that. Indeed, studies have documented that the costs of billing and related functions make up 10 to 15 percent of operating revenue for practices.[4] In short, because a major portion of billing costs are fixed and apply to any service regardless of the payment level, practices would bear transaction costs approaching or exceeding the payment they would receive.

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[3] Phillip Tseng, Robert S. Kaplan, Barak D. Richman, Mahek A. Shah, and Kevin A. Schulman, "Administrative Costs Associated with Physician Billing and Insurance-Related Activities at an Academic Health Care System," *JAMA* 319, no.7 (2018): 691–97.

[4] Bonnie B. Blanchfield, James L. Heffernan, Bradford Osgood, Rosemary R. Sheehan, and Gregg S. Meyer, "Saving Billions of Dollars—and Physicians' Time—by Streamlining Billing Practices," *Health Affairs* 29, no. 6 (2010):1248–54; James G. Kahn, Richard Kronick, Mary Kreger, and David N. Gans, "The Cost of Health Insurance Administration in California: Estimates for Insurers, Physicians, and Hospitals," *Health Affairs* 24, no. 6 (2005): 1629–39; Julie Ann Sakowski, James G. Kahn, Richard G. Kronick, Jeffrey M. Newman, and Harold S. Luft, "Peering into the Black Box: Billing and Insurance Activities in a Medical Group," *Health Affairs* 28, no.4 (2009): w544–54.

And that is just the billing cost for the first submitted claim from the practice. A typical claim for a MPFS service is generated by the practice and sent to a Medicare administrative contractor, which adjudicates the claim and makes a payment to the practice for Medicare's portion. The contractor passes the claim to a supplemental insurer, such as a Medigap carrier, which determines its portion and informs the practice what it can bill the patient for applicable beneficiary cost-sharing, at which point the practice generates another bill for the patient. Even with electronic transfer, this cycle of claiming and paying requires many manual steps, and the cumulative costs clearly exceed the $20 for the initial claim.

Practices understand this billing reality. CMS adopted a "virtual check-in" code in the 2019 MPFS for short (5- to 10-minute) phone calls with patients to sort out whether patients needed to come in for an office visit. The "correct" national fee according to usual relative cost determination was about $15. Although the check-in call may make good clinical sense in some situations, it failed from a financial point of view. Not surprisingly, practices rarely billed for the service, suggesting that practices considered the relatively meager payment too little to justify the even higher billing costs. The result was that Medicare allowed less than $200,000 for this code in 2019 (compared with total spending under the MPFS of more than $90 billion.)

Perhaps CMS learned the lesson of payment levels below billing costs. Within a few weeks of adopting payment for phone calls during the public health emergency, CMS raised the payment for a 5- to 10-minute phone call from $15 to a more acceptable $46 – the rate for a level 2 office visit. It made perfect policy sense during the public health emergency to get money out to financially strapped practices while also facilitating needed access for beneficiaries to their practitioners. However, retaining this three-fold increase in the proper fee (indeed, adopting complete pay parity) presents an unresolvable dilemma for policymakers. Using standard, relative cost calculations, the fees for many desirable "small-ticket" items would be too low to justify practices performing them and/or billing for them. Yet raising the fees to make it financially worthwhile for the practices would create a major precedent for ignoring relative values based on relative resources, thereby opening up the fee schedule to special pleadings from many stakeholders.

Paul Ginsburg (the vice chair of MedPAC) and I wrote a paper in 2019 arguing that it is time for the MPFS to move off of strict adherence to relative costs to determine fees (Berenson and Ginsburg 2019)[5]. This could be accomplished by both (1) altering fee levels for likely overpriced services by examining service volume changes that occur in response to initial fee changes, usually fee reductions, and (2) seeking to accomplish specific policy objectives that could be supported by fee changes, usually providing increases in underpriced services, such as to increase the attractiveness and supply of primary care health professionals. Pay parity for telehealth services in the face of research that shows substantially lower production costs[6] should not be adopted as a policy "one-off" under the current pressure to generously expand telehealth. Rather, such parity should be considered only as part of a more comprehensive approach to modifying how MPFS fees are determined. Doing otherwise could lead to a policy free-for-all

[5] Robert A. Berenson and Paul B. Ginsburg, "Improving the Medicare Physician Fee Schedule: Make It Part of Value-Based Payment," *Health Affairs* 38, no. 2 (2019): 246-252.

[6] J. Scott Ashwood, Ateev Mehrotra, David Cowling, and Lori Uscher-Pines, "Direct-to-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending," *Health Affairs* 36, no. 3 (2017): 485-491.

in which plausible (but self-interested) pleadings are advanced outside of a disciplined process for weighing the merits of fee changes. Dr. Ginsburg and I argued that CMS, under the guidance of a formal Federal Advisory Committee Act–compliant committee, should have the authority to change fees considering factors other than relative costs.

3. Increased Volume and Spending

I anticipate that patients and their families will love the alternative of video-based telehealth and much greater use of phone communications with their practitioners and primary care team members. Patients face substantial time costs and inconvenience in traditional travel, waiting rooms, and actual time with the practitioner. I recently waited 20 minutes *after* my visit just to check out. The routine annual wellness visit took about three hours altogether (admittedly with some delays created by COVID-19 concerns).

I would reiterate that telehealth should be advanced substantially as a potential game-changer in how care is delivered. My objection lies in using fee schedule payments as the way to compensate the practices when alternatives exist that can be adopted and adapted over time. Without the constraints of consumer time and inconvenience, the potential for a spending explosion is real, especially if policymakers resolve the pricing dilemma posed above by paying far above production costs, as pay parity would do. Furthermore, important work by researchers at RAND (performed before the COVID-19 pandemic) found that 90 percent of telehealth services were additional services rather than substitutes for in-person services.[7]

Clearly, that has not been the case during the public health emergency, during which virtual visits became the only way for patients to receive timely care for a period of time. Nevertheless, used properly, telehealth very often *should be* an add-on to often insufficient in-person care, especially for chronic care management but also, for example, to clarify whether a tentative diagnosis was correct, to monitor the effect of adding a medication or changing a dosage, or for myriad other potential clinical reasons. But those add-on, virtual services need to be managed by the practice within a spending constraint to help assure that virtual visits are used appropriately.

4. Alternative Payment Methods for Telehealth

Fee schedule payments should be limited to virtual visits equivalent to high-level office visits and paid somewhat less than office visits, in line with relative cost calculations as usual. There may be compelling reasons to pay fee-for-service for unique provider types. A challenging issue is whether Medicare should routinely pay for telehealth vendors that do not have established relationships with beneficiaries as do many private insurers (but not Medicare). Younger patients often do not have established relationships such that an occasional telehealth vendor encounter can make good clinical sense as a reasonable convenience for patients. But for Medicare beneficiaries, policy in general should encourage continuous, established relationships, not occasional telehealth vendor visits supported through fee-for-service.

[7] Ashwood et al., "Direct-to-Consumer Telehealth May Increase Access to Care but Does Not Decrease Spending."

Assuming established relationships between clinicians and patients, telehealth is best paid through PPPM payments to cover the costs of robust telehealth. Currently, CMS is working to test various forms of hybrid payment models that would pay partly by fee schedule and partly by a monthly PPPM, called capitation. The latter approach pays the practice for patients who are expected to seek care initially from their chosen or assigned practice (but remain free to seek care elsewhere). The payment is adjusted for the person's underlying health risks and represents an average amount for the population of beneficiaries with similar health risks.

Capitation incentives are fundamentally different from fee-for-service: the practice receives the funds regardless of how many services they provide an individual for whom payment is received. The incentives are reversed—the practice is rewarded for keeping patients healthy and not in need of health services. And the approach should reward broad use of telehealth when a virtual visit or phone call suffices without need for an in-office visit. There would be no billing costs associated with the telehealth provision, and, indeed, beneficiary cost-sharing for the capitation portion of the hybrid payment could be waived altogether under a well-functioning hybrid model. Initially, maintaining fee schedule payments for some services (including in-office visits) would help mitigate the expressed concern about stinting on care (i.e., accepting the PPPM payments but stinting on actually providing care).

In my view, the compelling need to find an alternative to fee schedule payments for telehealth calls for expediting the design and testing of the Center for Medicare and Medicaid Innovation's (CMMI) model called Primary Care First on a regional and mandatory basis. It has the potential to be the alternative permanent payment model for primary care practices while also addressing payment for telehealth services.

Paying for telehealth for specialists presents a different challenge, because many specialists do not and should not have continuous, established relationships. Based on analyzing the use of telehealth by specialty during the public health emergency, specialty practices that provide a large amount of telehealth services could receive lump sum, monthly payments that they control and use for appropriate application of virtual care. The practices would allocate the funds for telehealth services as they deem appropriate and not have to submit claims for each instance. Some accounting would be necessary to ensure that the telehealth services were actually provided.

5. Conclusion

Congress and CMS face an urgent need to adequately fund telehealth services as an essential component of 21st century health care delivery. However, payment should not simply continue public health emergency-based flexibilities and generous payments that are important to allow during the COVID-19 pandemic. It would be a policy mistake not to use this unique opportunity not only to provide a better payment method to support virtual healthcare and other evaluation and management services, including in-office services, but also to reform how Medicare Physician Fee Schedule fees are determined in the first place.

Telehealth should not be supported primarily through fee-for-service, but rather through hybrid payment methods that should include capitation for primary care practices and periodic lump sum

payments for specialists. The latter approach has not been tested and will need immediate development and pilot testing. Continued fee schedule payments for telehealth should be limited to lengthy, virtual care encounters and for particular clinicians and other providers that do not have continuous, established relationships with patients. Policy should encourage development of established relationships, especially for the Medicare population, who often have multiple, interacting chronic conditions.

Admittedly, pursuing these recommendations would be challenging; it would be easier politically and operationally to simply ratify the PHE changes going forward, as many stakeholders advocate. That would be a mistake both because it could produce sustained increases in Medicare spending for years to come and because of the missed opportunity presented by telehealth to adopt alternative payment models that would produce greater value than even improved fee-for-service is able to produce. True value-based payment, although aspirationally worthy, has been difficult to accomplish. Telehealth provides a ready opportunity to make a virtue of necessity. Congress should not allow the opportunity to pass by.