



# Improving Care for Patients with Serious Illness: Part One

*October 2018*



BIPARTISAN POLICY CENTER

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## HEALTH CARE PAYMENT AND DELIVERY PROJECT CO-CHAIRS

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### **Senator Tom Daschle**

*Former Senate Majority Leader  
BPC Co-Founder*

### **Senator Bill Frist, MD**

*Former Senate Majority Leader  
BPC Senior Fellow*

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## SERIOUS ILLNESS ADVISORY COMMITTEE

The project leaders would like to thank members of the advisory committee for lending us their time and expertise on this project. Members include:

### **Edo Banach, J.D.**

*President and CEO  
National Hospice and Palliative Care Organization*

### **Cheryl Matheis, J.D.**

*Strategic Advisor  
Coalition to Transform Advanced Care*

### **Corey Davison**

*Vice President, Government Relations  
Tenet Healthcare*

### **Diane Meier, M.D., FACP**

*Director  
Center to Advance Palliative Care*

### **Tim Engelhardt, MHS**

*Director  
CMS Medicare-Medicaid Coordination Office*

### **Keith Mueller, Ph.D.**

*Director, Center for Rural Health Policy Analysis  
Rural Policy Research Institute*

### **Alesia Frerichs, M.S.**

*Vice President, Member Engagement  
Lutheran Services in America*

### **Marisa Scala-Foley**

*Director, Aging and Disability Business Institute  
National Association of Area Agencies on Aging*

### **Anna Gosline**

*Senior Director of Health Policy and Strategic Initiatives  
BCBS Massachusetts*

### **Robert Schreiber, M.D.**

*Vice President and Medical Director of Summit  
ElderCare  
Fallon Health*

### **Atul Grover, MD, Ph.D.**

*Executive Vice President  
Association of American Medical Colleges*

### **René Seidel**

*Vice President, Programs and Operations  
The SCAN Foundation*

### **Julian Harris, M.D., MBA**

*President  
CareAllies*

### **Brad Smith, MPhil**

*CEO  
Aspire Health*

### **Missy Jenkins**

*Vice President of Public Policy  
Alliance for Aging Research*

### **Nora Super, MPA**

*Director of Policy and Programs, Center for the Future  
of Aging  
Milken Institute*

### **Cindi Jones, M.S.**

*Senior Vice President, Government Relations  
InnovAge*

### **Peter Leibold, J.D.**

*Chief Advocacy Officer  
Ascension*

---

## STAFF

### **Katherine Hayes**

*Director, Health Care Payment and Delivery*

### **Natalie Weiner**

*Project Manager, Health Care Payment and Delivery*

### **G. William Hoagland**

*Senior Vice President*

### **Elexa Rallos**

*Project Assistant, Health Care Payment and Delivery*

### **Janet Marchibroda**

*Fellow, Health Innovation*

### **Marisa Salemme**

*Senior Policy Analyst, Health Care Payment  
and Delivery*

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## ADVISORS AND FORMER STAFF

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## HEALTH CARE PAYMENT AND DELIVERY PROJECT

Under the leadership of former Senate Majority Leaders Tom Daschle and Bill Frist, the Bipartisan Policy Center's Health Care Payment and Delivery Project develops bipartisan policy recommendations that will improve health care quality, lower costs, and enhance health care coverage and delivery. The project focuses on coverage and access to care, delivery system reform and cost containment, and long-term care.

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## DISCLAIMER

The findings and recommendations expressed herein do not necessarily represent the views or opinions of the Bipartisan Policy Center's founders, its board of directors, or the Serious Illness Advisory Committee.

# Glossary of Acronyms

**ACO:** Accountable Care Organization

**BBA:** Bipartisan Budget Act

**CCM:** Chronic Care Management

**CHIP:** Children's Health Insurance Program

**CHRONIC Act:** Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act of 2017

**CMMI:** Center for Medicare and Medicaid Innovation

**CMS:** Center for Medicare and Medicaid Services

**CSA:** Controlled Substances Act

**D-SNP:** Dual-Eligible Special Needs Plans

**E&M Codes:** Evaluation & Management Codes

**eNLC:** Enhanced Nurses Licensing Compact

**FFS:** Fee-For-Service

**HHS:** U.S. Department of Health and Human Services

**MA:** Medicare Advantage

**MACPAC:** Medicaid and CHIP Payment and Access Commission

**MMP:** Medicare-Medicaid Plan

**MSSP:** Medicare Shared Savings Program

**TCM:** Transitional Care Management

**TRC:** Telehealth Resource Center



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# Foreword

This is the first of a two-part series on serious illness. This first report focuses on changes to Medicare payment and delivery models as well as improvements in access to care through telehealth. The second report will offer recommendations to improve support to family caregivers and to create a more sustainable and viable direct-care workforce.

## Executive Summary

Americans with serious illness, their families, and caregivers, face significant challenges in the U.S. health care system. They have health conditions that (1) carry a high risk of mortality, (2) limit their ability to live independently, and (3) cause them to rely heavily on caregivers to help them remain at home.<sup>1</sup> Many have trouble performing everyday tasks such as bathing, dressing, and preparing meals, and may be at risk for falls. Individuals with serious illness may live for many years with a health condition. And while those with serious illness span every age, the rapid increase in the number of Americans over age 65 with serious health conditions and functional limitations has spurred researchers and practitioners to focus on and advocate for more effective and person-centered models of payment and delivery of services under Medicare, the primary source of insurance for older Americans.

A study by Discern Health identified key characteristics of payment and delivery that result in the highest-quality care for those with serious illness.<sup>2</sup> Those characteristics include: access to in-home services, including the use of telehealth services; care coordination services; individual care plans based on patient and caregiver needs; and interdisciplinary care teams that communicate regularly and monitor changes in a patient's health or functional status. Research has also shown that the provision of certain social services and supports not typically covered by health insurance can help those with serious illness remain at home.

Congress and the Trump administration have taken steps in the last year to provide flexibility in Medicare Advantage, Medicare's managed care plans, that allow health plans to target non-medical health-related supplemental benefits to patients with multiple chronic conditions. While a comprehensive approach to the financing and delivery of long-term services and supports is needed, there are policy changes that, in the short-term, can improve access to services for those with serious illness. The first section of this report recommends changes to Medicare reimbursement. Because traditional Medicare fee-for-service does not cover non-medical health-related services, researchers and many policymakers have concluded that existing payment models must be revised and new payment models developed to provide high-quality care for those with chronic conditions, including those with serious illness.<sup>3</sup>

In many areas of the country, however, fee-for-service is the only option available to Medicare beneficiaries. And though Congress has intervened to increase Medicare Advantage payments as an incentive to plans to offer care, the result has only increased Medicare costs without demonstrating additional value.<sup>4</sup> This report suggests changes in Medicare fee-for-service, in Medicare Advantage, and recommends the development and testing of a serious illness payment model through the Center for Medicare and Medicaid Innovation. This report also outlines barriers to the adoption of telehealth services. While telehealth is not the complete solution to improving care for those with serious illness, telehealth has the potential to improve access to providers in medically underserved areas, both urban and rural. Telehealth services also have the potential to allow patients who have significant functional limitations to receive some services in their homes, where they are more comfortable.



# Improving Access to Care for Patients with Serious Illness: Reimbursement

## INTRODUCTION

Today, patients with serious illness have considerable difficulty navigating Medicare's payment and delivery system. Providers, patients, and their caregivers must cobble together a combination of services covered by Medicare and Medicaid, supplemental services provided by public and private social-services agencies, as well as personal care from paid and unpaid caregivers. Too often services are based on what is reimbursed under Medicare, rather than what patients want and need to remain in their homes. This often leads to care in institutional settings such as hospitals and skilled nursing facilities at a much higher cost.

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*Too often services are based on what is reimbursed under Medicare, rather than what patients want and need to remain in their homes.*

## Medicaid

For those who are low-income, Medicaid may cover the cost of social services and supports provided in the home. The availability of home-based services under Medicaid depends largely on the state in which a patient resides. Medicaid covers some of the cost of non-medical health-related services through state plans or home- and community-based waivers, however those services are available to Medicare beneficiaries only after they exhaust their financial resources. Further, in most cases, they must wait until they have reached a functional level that would require a nursing home level of care. Because home and community-based services are provided through waivers that limit the number of individuals they serve, patients may spend significant time on waiting lists. Where services are available, there is often a shortage of direct-care workers to act as paid caregivers. All too often, patients remain in their homes without necessary care, until they have an adverse event that requires hospitalization, rehabilitation, and/or nursing home care.

## Medicare

Older Americans with serious illness can benefit from both traditional clinical health services and from non-medical health-related services and supports.<sup>5</sup> While some of these non-medical health-related services can prevent unnecessary hospitalization and emergency department visits,<sup>6</sup> they are not covered under the Medicare program. A recent study demonstrated that providing medically tailored home-delivered meals to low-income Medicare beneficiaries reduced overall spending and resulted in fewer emergency department visits and fewer inpatient hospitalizations.

## Palliative Care and Hospice

Palliative care interventions are designed to control the symptoms of serious illness, coordinate care, and improve communication among patients, providers, and families. These interventions improve quality of life, support patients and families, and in many cases, lower costs.<sup>7</sup> These services are generally unavailable to Medicare beneficiaries unless they are eligible for and enrolled in Medicare's hospice benefit. Hospice requires that patients be certified by a physician as having a terminal illness. The physician must also certify that the patient is not expected to live more than six months. Patients must also forgo curative care or medical treatment for their condition. Not all patients with serious illness are eligible for hospice care, and those who do qualify may be unwilling to stop active treatment.

## **Home Health**

Medicare's home health benefit covers certain core medical and medically related services in the home. To qualify, a physician must certify that a patient is home-bound and needs one or more of the following services: intermittent skilled nursing care, physical therapy, occupational therapy, or speech-language pathology services. Once a patient qualifies, they may receive personal care services such as help bathing or dressing. Services are provided through a home health agency.

## **Medicare Advantage**

Many of the social services needed by those with serious illness are provided by local public agencies or non-profit organizations, including faith-based organizations. Today Medicare Advantage (MA) plans and health care providers often refer patients to these community-based organizations, which provide services at no cost or low cost. These organizations often struggle, however, to keep up with the demand for services in their communities because of limited resources.



# Recommendations in Medicare

## Changes in Medicare Payment and Delivery for Patients with Serious Illness

### RECOMMENDATION

The Center for Medicare and Medicaid Innovation should test a Medicare payment and delivery model that is specifically designed for patients with serious illness.

### BACKGROUND

The Center for Medicare and Medicaid Innovation (CMMI) is currently testing a variety of value-based payment models; however, none of them are designed to address the unique needs of patients with serious illness. MA, accountable care organizations, and medical home models include a broad mix of patients with significant differences in health status. Recently, Congress has taken steps through the Bipartisan Budget Act (BBA) to allow targeting of supplemental services in MA. While this change could help improve access to services for patients with serious illness, absent significant flexibility in regulations, and broad offering of services by MA plans, this new policy may have limited impact.

Providers, researchers, and other experts have developed payment and delivery models designed to meet the unique needs of patients with serious illness. The Physician-Focused Payment Model Technical Advisory Committee, a committee developed to provide advice to the Center for Medicare and Medicaid Services (CMS), recommended that the secretary of the U.S. Department of Health and Human Services (HHS) test serious illness payment models—and the HHS secretary has expressed support.<sup>8</sup> CMMI should consider the two models recommended by Physician-Focused Payment Model Technical Advisory Committee:

- The Patient and Caregiver Support for Serious Illness model, which is designed to incentivize care coordination, concurrent curative and palliative treatment, advance care planning, and shared decision making for patients with one or more chronic conditions, with a high one-year mortality risk, and with high acute care utilization and functional or nutritional decline.<sup>9</sup> The model utilizes a per member per month care management fee for providers, coupled with shared savings to support a team-based approach shared financial risk for the cost of care for enrolled patients.
- The Advance Care Model, developed by members of the Coalition to Transform Advanced Care, includes a per-member, per-month care management payment; shared savings and risk through population-based payments that reward performance; and incremental integration with existing value-based payments and alternative payment models. It also features payment to support participation by specialists and primary care providers, including small physician practices; a transitional pathway from volume to value in rural areas; and voluntary multi-payer participation, including Medicare Advantage, Medicare-Medicaid Plans, and commercial payers.<sup>10</sup>

### RECOMMENDATION

In considering proposed changes to evaluation and management (E&M) services in the calendar year 2019 physician fee schedule—including collapsing evaluation and management codes into two categories, using new add-on payments, and adding the proposed changes in E&M codes related to telehealth—CMS should consider the impact of the combined proposals on access to care for those with serious illness and whether the collective policies incentivize providers to avoid high-risk patients. Recognizing that E&M services are undervalued, the HHS secretary should collect information and revise codes to more accurately reflect the cost of providing services to patients with serious illness.

## BACKGROUND

E&M accounted for more than a quarter of services billed under the Medicare physician's fee schedule in 2016. E&M services are provided during an office or hospital outpatient visit. There are five levels of E&M services, with level one representing the least amount of resources expended by the provider and level five representing the most intensive amount. Practitioners are required to document the services provided, including the history of diagnosis, an examination, and the complexity of the service determined by the number of diagnoses and treatment options, the amount of information, and the potential for complications.<sup>11</sup> The more complex the visit, the higher the level of code a provider may bill within the appropriate category.

E&M codes have been traditionally undervalued in Medicare reimbursement and do not accurately reflect the cost or value of the services.<sup>12</sup> CMS has proposed changes in the value of E&M codes under the Medicare physician fee schedule for calendar year 2019, which could exacerbate this problem, resulting in negative consequences for patients with serious illness. The purpose of the proposed changes, according to CMS, is to simplify the administrative burden by eliminating documentation. CMS also proposed reducing the number of payment levels within the E&M code list from five levels to two and establishing different payment rates for new versus established patients. Providers have argued that collapsing E&M codes from five levels to two would mean payments are reduced for more complex patients who require more time per visit. To mitigate this, CMS has also proposed establishing a new series of add-on codes that would pay an additional \$5.41 to \$67.41 per visit based on the length of visit or patient complexity. MedPAC has raised concerns that these services are underpaid relative to other services and that CMS has not adequately reviewed the cost of services.<sup>13</sup> MedPAC has also raised concerns that changes proposed by CMS will provide incentives for providers to avoid more complex patients. Given the complexity of patients with serious illness, there is a concern that this change could limit access for patients.

## RECOMMENDATION

Congress should enact legislation to eliminate the beneficiary co-payments for chronic care management services for calendar years 2020, 2021, and 2022. CMS should conduct an evaluation to determine whether elimination of the co-payment increased use of the services, as intended by the policy. The HHS secretary should also collect data on whether payment is sufficient to promote coordination of care for patients with serious illness and adjust the payment based on that data no later than calendar year 2023.

## BACKGROUND

Medicare pays practitioners for chronic care management services performed outside an office visit for patients with two or more chronic conditions. Services may be billed—if the condition is expected to last 12 months or until the death of the patient and if the conditions place the beneficiary at risk of death, exacerbation of the condition, or functional decline. Health care providers, including physicians, physician assistants, clinical nurse specialists, nurse practitioners, and certified nurse midwives may bill for chronic care management (CCM) services and receive a per-month payment if they spend a minimum of 20 minutes per month on coordination services. Providers must document in a patient's medical record that services were explained to the patient, including the 20 percent co-payment, and that the patient consented to the services.<sup>14</sup>

In 2016, approximately 684,000 Medicare fee-for-service (FFS) beneficiaries received CCM services during the first two years of implementation of the CCM benefit,<sup>15</sup> generally amounting to less than 5 percent of Medicare FFS patients who were potentially eligible for CCM services.

There are a number of potential explanations for low utilization. One reason cited is that services are furnished outside the office visit and involve communications among the providers; beneficiaries are often unaware that a service has been provided and do not see the value of the service. Others have suggested that provider payments do not reflect the time and effort spent on coordinating care across providers.



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## RECOMMENDATION

CMS should clarify the language in both CCM and transitional care management code guidance to permit qualified health providers, such as licensed clinical social workers, to bill under both codes for clinical staff time on the interprofessional team.

## BACKGROUND

In Medicare FFS, physicians, nurse practitioners, and physician assistants can be reimbursed for both chronic care management and transitional care management. They can also submit bills based on time and intensity of services under FFS Medicare. Transitional care management (TCM) services include the coordination and management of a patient's care for the first 30 days after returning home or to the community. In addition to the previously described limited diffusion of CCM services, growth in the prevalence of TCM was also narrow, with roughly 950,000 instances of providers billing Medicare for TCM services in 2016.<sup>16</sup>

While licensed clinical social workers are permitted to provide and bill for behavioral health services, they are not expressly included in the list of providers for CCM or TCM, though they are often part of the care team and clinical staff. Additionally, licensed clinical social workers often perform care management activities. However, because they are not expressly identified as non-physician practitioners eligible to bill for CCM or TCM, they cannot bill for these services.

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## RECOMMENDATION

Congress should direct the HHS secretary to eliminate beneficiary co-payments for advance care planning for calendar years 2020, 2021, and 2022. The secretary should conduct a review to determine the impact on use and make a recommendation to Congress to permanently waive co-pays if the waiver increases utilization and promotes improved patient decision making.

## BACKGROUND

Advance care planning (ACP) is the face-to-face time a provider spends with a patient, family member, or surrogate to explain and discuss end-of-life decisions and advance directives. If this conversation occurs during the Medicare annual wellness visit, there is no associated co-payment. However, if it occurs at any other time, the conversation is subject to beneficiary cost sharing. For example, some beneficiaries may need ACP multiple times in a year if they are seriously ill and/or their health status changes, in which case they would also have to pay the co-insurance and/or deductible.

ACP is regarded as a public health issue by the Centers for Disease Control and Prevention, given its "potential to prevent unnecessary suffering and to support an individual's decisions and preferences related to the end of life."<sup>17</sup> Since the introduction of ACP as a billable service, ACP billing code utilization has continued to rise. However, the rate of Medicare reimbursement for ACP diminished: 39 percent of the claims filed in January through June 2017 were reimbursed versus 46 percent for 2016. Per CMS, this difference represents growing patient co-pays and deductibles for ACP. Though the ACP codes are relatively new (since 2016), this increase in beneficiary cost sharing is anticipated to be a barrier to ensuring that patients have a full understanding of care options and receive the care they want. Bipartisan legislation has been introduced in the House and Senate that, among other provisions, would eliminate beneficiary cost sharing for ACP services.<sup>18</sup>

# Improving the Availability of Non-Medical Health-Related Services and Supports in the Home and Community

## RECOMMENDATION

The HHS secretary should direct CMS and the Administration for Community Living to develop a model contract that could be used to facilitate referrals, coordination, and reimbursement for non-medical health-related services. In developing the model contract, the secretary should consult with MA plans, community-based organizations, and public and private agencies. MA plans and community-based organizations could use the model contract to facilitate partnerships between plans and established social-service providers in a community.

## BACKGROUND

As health care organizations recognize the impact of non-medical needs on health outcomes, partnerships between plans and community-based organizations have increased. The community-based organization network provides types of non-medical health-related services to seniors—especially high-risk seniors and other vulnerable populations—every day. This network includes housing organizations, workforce-development agencies, food banks, and nutrition delivery services such as Meals on Wheels America. Community-based organizations, as part of service delivery, also allow for important personal interactions to help address issues of social isolation.

As providers and insurers have learned more about successful non-medical interventions, there has been an increase in referrals for these services for patients with serious illness. At the same time, declining state and federal funding resulted fewer resources, leading to waiting lists and service denials. Community-based service providers must seek new ways to finance services, including contracting with health insurers, to help finance costs. In many areas of the country, particularly rural areas, progress has been slow. If MA plans take advantage of the new flexibility to provide supplemental benefits for patients with multiple chronic conditions, plans should be encouraged to take advantage of cost-effective, community-based providers that have experience in providing care to patients with serious illness, rather than duplicating services.

Managed care organizations typically seek to, where possible, use a single master service agreement for all outside subcontractors—which complicates the ability of a local organization to contract with a national insurer, like the issuers that enroll patients in the MA program.<sup>19</sup> Some community-based organizations report that as local, non-profit organizations, they lack the expertise and business acumen necessary to secure contracts with managed care organizations to provide non-medical health-related services to a health plan's enrollees. This is especially true of smaller community-based organizations. The contract's terms and obligations are often complex, far-reaching, and long-lasting.

Without the technical or legal expertise to contract with MA plans or other entities, there is concern that community-based organizations will continue to receive unfunded referrals in a new regulatory environment that allows plans to cover and pay for many of the types of services provided by local community-based organizations. In recognizing the important role these organizations play, the Administration for Community Living formed a public-private partnership to improve these organizations' business acumen.<sup>20</sup>

Establishing a CMS-approved model contract between plans and community-based organizations can help facilitate referral and reimbursement by sending a signal that CMS encourages these arrangements. Contracting could accelerate and promote community organizations as critical partners in the delivery of care. In developing the model contract, the HHS secretary should work with all stakeholders and, where appropriate, develop incentives to support the use of non-health-related services to support successful population management.



## RECOMMENDATION

The HHS secretary should provide guidance to plans to clarify that the “improve or maintain” standard in the BBA regarding MA plans does not preclude plans from offering non-medical health-related services to patients with serious illness whose health status may be expected to decline, rather than to improve or maintain at the current level.

## BACKGROUND

The BBA incorporated many provisions from the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act that aim to improve care in Medicare for high-needs beneficiaries. Signed into law on February 9, 2018, the BBA gives plans greater flexibility in providing the types of non-medical health-related services discussed in this report. Beginning in plan year 2020, MA plans will be able to target supplemental benefits, such as installing grab bars in areas other than a bathroom or providing home-delivered meals, to individuals with multiple chronic conditions. Today, meals may only be provided immediately after a hospital discharge. These types of supplemental services were also subject to Medicare’s uniform benefit requirement, which prohibited targeting supplemental benefits to a subset of enrollees.

The BBA gave MA authority to target non-medical health-related benefits to patients with multiple chronic conditions. Whether this additional flexibility will improve care for patients with serious illness will depend in large part on striking the appropriate balance between providing sufficient guidance to plans to make them comfortable that they will not be audited for violating MA rules and enough flexibility to allow them to target benefits to specific populations.<sup>21</sup>

The degree of flexibility that CMS will provide is unclear—and if the MA final rule for plan year 2019 is an indication, the answer may be very little flexibility. For example, the final rule for plan year 2019, prohibits plans from offering medically targeted home-delivered meals, a service that has been shown to lower the cost of care for certain patients.<sup>22</sup> Hopefully, this policy will change as CMS fully implements the chronic care provisions of the BBA. However, even if CMS revises policy for plan year 2020, it is unclear whether plans will take advantage of the new flexibility. Critical to the success of MA’s new flexibility is the willingness of the plan to offer additional services and its ability to appropriately target services.

To gain a better understanding of the range of supplemental services offered across MA plans, as evidenced by their inclusion in publicly available plan documents, BPC contracted with Leverage Global Consulting. This analysis involved both quantitative and qualitative analysis as well as policy and regulatory materials to better understand and identify the available data that could be used to develop a baseline on current practice, incentives, barriers, and opportunities that may drive carrier decision making about benefits and service plan designs. Developing a baseline could be valuable in assessing the impact of the chronic care provisions of the BBA on those with serious illness and their caregivers as it is implemented over the coming years. At the same time, it provides a snapshot of the significant variation in amount, scope, and duration of benefits, as well as the lack of awareness of enrollees as to the availability of supplemental benefits (see Appendix A).

CMS will need to make important decisions regarding which enrollees qualify for certain non-medical health-related benefits. For example, while home-delivered meals may improve or maintain the health or functional status of a person with a diagnosis of diabetes and high blood pressure, for a person with a diagnosis of diabetes and a *terminal illness*, a plan might determine that a home-delivered meal may not reasonably be expected to help the person improve or maintain health or functional status, given expected decline in health status with or without the intervention.

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## RECOMMENDATION

CMS should better align need with benefits by basing eligibility for targeted supplemental benefits in MA on functional limitations or a combination of functional limitations and diagnosis, rather than diagnosis alone.

## BACKGROUND

Assessing patients' frailty and functional limitations is important in identifying patients with serious illness who are likely to benefit from care management and better integration of health-related supports. However, federal health care programs lack consistent standards for and use of functional assessment tools to determine patients' frailty. In Medicare FFS, patients are unlikely to receive functional assessment to begin with, unless the patient receives post-acute care services following an inpatient hospitalization.<sup>23</sup> Although the incorporation of functional assessment as a component of the Medicare FFS annual wellness visit allows for the potential to identify functional status in the non-post-acute-care community setting for more patients, use of the annual wellness visit remains low, with just 17 percent of Medicare FFS beneficiaries receiving an annual wellness visit in 2016.<sup>24</sup>

Even when a patient receives a functional assessment, the information provided is often inconsistent across the different functional assessment tools in various settings in both Medicare and Medicaid.



# Providing Guidance on Consumer-Directed Care in Medicare Advantage

## RECOMMENDATION

As CMS develops regulations to implement MA flexibility in the targeting social services, CMS should develop guidance for MA plans to encourage a consumer-directed option. This option should be evaluated after a period of time to identify use of the option among MA participants, ways to optimize the delivery of the services and supports, and appropriate measures of quality for home and community-based services.

## BACKGROUND

As MA plans begin to make non-medical health-related services and supports available to targeted populations, CMS has not yet provided guidance on allowing a consumer-directed option for the targeted supplemental services, so that those enrollees and families have greater autonomy in the provision of this care. Consumer direction of services are a hallmark of Medicaid personal care programs. In Medicaid, states allow consumer direction of personal assistance services, which help an individual with activities such as bathing, cooking, and dressing. This provision gives the Medicaid beneficiary, rather than traditional home health agencies, greater flexibility in hiring, scheduling, training, and paying personal care attendants.<sup>25</sup>

As MA plans begin to make non-medical health-related services and supports available to targeted populations through supplemental benefits, allowing those patients and families to be involved in the provision of this care could be an option. This would be a new development in Medicare. Currently, all personal care assistants working in Medicare home health are considered “skilled care,” requiring a certified nurse’s aide to work under the direct supervision of a nurse. This certified nurse’s aide training includes skills used exclusively in institutional settings; its use in training home health workers is cited as an example of the “medicalization” of providing non-medical supports in the home. While the BBA chronic care provisions will improve the ability of MA plans and risk-bearing payment models to integrate Medicare-covered clinical care and non-medical but health-related supports, there is consumer concern consumers about maintaining support for patient/consumer involvement.

# Improving Access to Care for Patients with Serious Illness: Telehealth

## INTRODUCTION

Telehealth is a rapidly growing and evolving method of providing health care via technology. The National Consortium of Telehealth Resource Centers defines telehealth as “a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies.”<sup>26</sup> HHS states that telehealth incorporates “direct, electronic patient-to-provider interactions and the use of medical devices to collect and transmit health information, often with the intent to monitor or manage chronic conditions.”<sup>27</sup> The demand for telehealth services is growing as Americans increasingly use technology in every other part of their lives. More than 90 percent of U.S. employers surveyed are currently providing or plan to provide coverage for telehealth services for their employees.<sup>28</sup> The majority of private health plans are providing coverage for telehealth within their commercial populations. HHS estimates that 60 percent of health care institutions, and between 40 and 50 percent of all hospitals, use some form of telehealth.<sup>29</sup>

The Agency for Healthcare Research and Quality categorizes telehealth into three groups:<sup>30</sup>

- *Real-time video (synchronous)*: involves the patient and his or her primary care provider or other health care professional interacting with a remote specialist via video-conferencing or other real-time telehealth technology.
- *Store-and-forward (asynchronous)*: involves the transmission of medical or health information, such as an x-rays, lab results, or prescriptions, from one provider to another for consultation or interpretation.
- *Remote patient monitoring*: involves the use of telehealth to remotely monitor health status. Data (e.g., weight, blood pressure, or glucose level) are captured via medical devices in the patient’s home and then transmitted to a provider via the internet.

## Benefits for people with serious illness

While those with serious illness have higher medical needs, they have greater difficulty accessing in-person care because of their limited mobility and potential geographic distance from their providers. Because of these challenges, these high-need patients often prefer to receive care in their homes and communities rather than in clinical settings.<sup>31</sup>

Telehealth has the potential to provide greater access to care for people with serious illness and allow patients to receive care when and where they want it. Clinicians and patients are using telehealth to improve care or increase access to care in a variety of ways: management of long-term treatments, post-discharge coordination and management in home- and community-based settings, consultations with off-site specialists, medication management and adherence, and more.<sup>32</sup>

These telehealth services have proved to be especially effective in improving outcomes for patients with multiple chronic conditions. Studies have shown improvements in measures such as mortality, quality of life, and hospital admissions.<sup>33</sup>

Additionally, communication among clinicians and across health facilities provides better and more patient-centered coordinated care, helping to fill the gaps of workforce shortages and the need for specialty care. Telehealth consultations between providers can be especially helpful in building capacity among rural practitioners, improving care for the patients and allowing them to stay in their communities for care.<sup>34</sup>





*Communication among clinicians and across health facilities provides better and more patient-centered coordinated care, helping to fill the gaps of workforce shortages and the need for specialty care.*

Evidence of health care cost reductions, however, is limited and mixed. While some studies show telehealth savings for specific populations, such as nursing home residents or people with chronic illness, there is concern that telehealth increases costs and utilization.<sup>35,36,37,38</sup> While telehealth is not the complete solution to improving care for those with serious illness, telehealth has potential for improving access to providers in medically underserved areas, both urban and rural. Telehealth services also have the potential to allow patients who have significant functional limitations to receive some services in their homes, where they are more comfortable.

## Recent Policy Changes

### *The BBA*

Many state legislatures are allowing more access to, practice of, and reimbursement for telehealth services, although some maintain restrictions on telehealth-related services. In 2018, legislators in 40 states introduced telehealth-related bills regarding reimbursement, private payer requirements, issues of consent, originating site distance, tele-pharmacy, broadband, and more.<sup>39</sup>

At the federal level, more than 20 agencies, including the U.S. Department of Veterans Affairs and CMMI, are engaged in efforts to increase access and to build necessary infrastructure.<sup>40</sup> Beginning in January 2018, CMS began reimbursement for remote patient monitoring by activating CPT code 99091 for separate payment under Medicare. As of June 2018, the 115th Congress saw the introduction of more than 70 bills that addressed telehealth, covering the issues of broadband expansion, rural health, specific treatments and conditions, and reimbursement policies, among others.

The BBA brought significant advances for Medicare telehealth coverage. The legislation enacted proposals from the House's Furthering Access to Stroke Telemedicine Act and the Increasing Telehealth Access to Medicare Act, as well as the Senate's CHRONIC Care Act:

- *Expand access to home dialysis therapy:* Beginning January 1, 2019, Medicare patients with end-stage renal disease may choose to receive their monthly clinical assessments via telehealth, expanding the list of eligible originating sites to include both freestanding dialysis facilities and the patient's home. Additionally, geographic distance restrictions would be eliminated. Patients who choose to use telehealth will be required to participate in a face-to-face clinical assessment during the first three months of home dialysis and every three months thereafter.
- *Expand the use of telehealth for individuals who have had strokes:* Beginning January 1, 2019, Medicare patients who present acute stroke symptoms at a hospital or critical access hospital, mobile stroke unit, or any other type of care site that CMS designates may receive a timely telehealth consultation to determine the best course of treatment, without regard to the geographic location of the care site.
- *Increase convenience for MA enrollees through telehealth:* Beginning in 2020, MA plans may offer additional, clinically appropriate, telehealth benefits in their annual bid amount beyond the services currently receiving payment under Medicare Part B. The HHS secretary is required to solicit comments on the types of telehealth services and the requirements for furnishing those benefits. If an MA plan offers a service via telehealth, they must also provide access to that service through an in-person visit, allowing the beneficiary to decide how to receive the service.
- *Permit accountable care organizations to expand the use of telehealth:* Beginning in 2020, some accountable care organizations (ACOs) can use the Next Generation ACO telehealth waiver, which waives geographic location restrictions and allows a patient's home to serve as an originating site. The waiver can be used in the Medicare Shared Savings Program (MSSP) Track II, MSSP Track III, and other two-sided risk ACO models with prospective assignments that are tested or expanded through CMMI. This provision would ensure that MSSP and ACO providers are only allowed to furnish telehealth services as currently specified under Medicare's physician fee schedule, with limited exceptions.

## Barriers

Although the BBA removed several federal restrictions on telehealth, lack of data and reimbursement remain the biggest barriers to adoption.<sup>41</sup> Despite progress in the private sector, Medicare limits reimbursement, which restricts access for many seriously ill people. For example, only live interactions are covered, originating sites are restricted to rural areas in which there are health professional shortages, and patients are limited in the types of facilities where they can receive services. While there have been numerous bipartisan legislative proposals to address these barriers, passage has been hampered by concerns over cost and scoring by the Congressional Budget Office.<sup>42</sup> Additional evidence is expected to emerge given increased adoption within the private sector as well as within MA following the BBA.

Barriers exist at the state level as well, including variability in state licensure requirements for clinicians practicing medicine via telehealth and prescribing medications across state lines. There is great variation in Medicaid coverage by state, including the type of service that is reimbursed and who can provide that service.

Clinicians also need access to education and training on evidence-based best practices to provide this new mode of care. Additionally, more work needs to be done to increase broadband in rural and underserved areas so that seriously ill individuals can receive this care.

BPC's recommendations are designed to address cost and evidence concerns.

## Proposed Changes in Calendar Year 2019 Physician Payment Rule

As part of the calendar year 2019 physician payment rule, CMS has proposed a category of communication-technology-based services. These new services would not be subject to statutory requirements imposed by Congress under section 1834(m) of the Social Security Act.<sup>43</sup> Under the proposed rule, providers would be permitted to bill for "virtual face-to-face check-ins," which include phone calls or emails to determine whether a patient's condition warrants an office visit. Providers must obtain patient consent and explain that services will incur beneficiary co-pays. The rule also permits remote evaluation of images, including video submitted to the provider by the patient, and verbal follow-up with the patient within 24 hours of the evaluation. However, if the services follow a related E&M visit in the previous seven days or the following 24 hours, then these communication-technology-based services would not be billable.

The proposed rule includes two additional telehealth service codes to permit provider billing of E&M services that exceed the typical service time of a primary procedure. These two codes represent time spent by the clinician for the first 30 minutes beyond the typical service time and each additional 30-minute block of time, respectively.<sup>44</sup> These provisions have the potential to improve access to care for patients with serious illness, but CMS should consider the impact of beneficiary co-pays for the additional codes relating to E&M.



# Recommendations in Telehealth

## Medicare Reimbursement for Telehealth

Medicare reimburses providers for telehealth services—but only if guidelines are met. Current restrictions are based on the type of provider, type of service, type of modality, and geographic location. Specific restrictions in the three Medicare payment systems—FFS, MA, and ACOs—vary. Congress has moved to expand coverage throughout the systems, and CMS continues to increase the number of reimbursable services through regulations that increase the number of permissible billing codes.

Medicare telehealth visits per beneficiary increased 79 percent between 2014 and 2016.<sup>45</sup> However, use remains concentrated among a small group of beneficiaries who tend to be under age 65, disabled, and dually eligible for Medicare and Medicaid.<sup>46</sup> Medicare's restrictions, especially in FFS, prohibit certain patients, including those who may be seriously ill, from accessing telehealth. Medicare treats telehealth “almost exclusively as a tool for rural areas,” yet beneficiaries in urban areas also face challenges.<sup>47,48</sup> Policymakers can build on the progress of the BBA in all three payment programs and move toward expanding Medicare's reimbursement for telehealth while ensuring this coverage does not increase health care spending.

## Waiving Store-and-Forward Restrictions

### RECOMMENDATION

Allow for reimbursement of the provision of store-and-forward technologies in all states by authorizing the HHS secretary to waive requirements for covered telehealth services if the secretary determines that the waiver will over the long-term (1) reduce spending without reducing the quality of care, or (2) improve the quality of patient care without increasing spending. Additionally, the chief actuary of CMS must certify that the waiver would reduce spending, or not result in any increase in spending, and the secretary determines that the waiver would not deny the provision of benefits to individuals.<sup>49</sup>

### BACKGROUND

Store-and-forward services are particularly helpful when consultation from a specialist is needed, which is often the case for patients with serious illness or special needs. Store-and-forward technology can be especially helpful for patients with serious illness and the providers who care for them. The Center for Connected Health Policy references five specific benefits of store-and-forward telehealth: (1) patients can get timely specialty care without needing to travel beyond the location of their primary care providers; (2) wait times for specialty care are lessened, especially in areas with shortages of medical specialists; (3) primary care providers and medical specialists can review patient cases, regardless of their respective locations; (4) medical specialists can review patient cases when it is convenient for them; and (5) the process can overcome language and cultural barriers.<sup>50</sup> Store-and-forward services are prohibited under Medicare FFS except for CMS demonstration programs in Alaska and Hawaii. Giving the HHS secretary flexibility via waivers could increase access for patients and providers in both urban and rural settings while ensuring the increase in access doesn't result in either overuse or an increase in cost.

## Removing Originating Site and Facility Restrictions

### RECOMMENDATION

Remove originating site restrictions, both geographic location and facility type, by authorizing the HHS secretary to waive requirements for covered telehealth services when the waiver will (1) reduce spending without reducing the quality of care, or (2) improve the quality of patient care without increasing spending. Additionally, the chief actuary of CMS must certify that the waiver would reduce spending, or not result in any increase in spending, and the secretary determines that the waiver would not deny the provision of benefits to individuals.

### BACKGROUND

An “originating site” is where a patient is located when they receive a telehealth service. Under Medicare FFS, beneficiaries are only eligible for telehealth services if the originating site is located in a rural “health professional shortage area” (as defined by the Health Resources and Services Administration) or a county outside of a “metropolitan statistical area” (as defined by the U.S. Census Bureau). In addition, originating sites under the Medicare FFS program are limited by facility type. The eligible facilities include provider offices, hospitals, critical access hospitals, rural health clinics, federally qualified health centers, skilled nursing facilities, and community mental health centers. As a result, seriously ill Medicare FFS patients who are homebound, are in long-term care facilities, or live in urban areas have limited access to telehealth services.

Removing originating site restrictions would give seriously ill patients more access to telehealth services, allowing them to receive care even if they aren’t in a designated shortage or rural area. Individuals in urban and suburban areas who still have difficulty accessing care because of health, mobility, or financial challenges would have more opportunities to receive their care via telehealth. The BBA removed these restrictions for the treatment of acute stroke, and the HHS secretary would be able to remove restrictions for conditions, sites, or areas that show similar promise for quality of care and cost.

## Easing Provider Restrictions/Expanding the Evidence Base

### RECOMMENDATION

Expand the list of health care professionals that can be reimbursed for telehealth services under Medicare FFS by pilot testing their services through a CMMI demonstration. This can be accomplished under existing CMMI authority, which permits further expansion of the telehealth evidence base through demonstrations that result in reduced spending without reduced quality of care, or with improved quality of patient care, and without increased spending. The HHS secretary should request that the U.S. Comptroller General study overall savings to Medicare associated with expansion of services.

### BACKGROUND

Medicare limits the types of health care practitioners that can be reimbursed for telehealth-delivered services. The current list of eligible providers includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, registered dietitians, clinical psychologists, and clinical social workers. (Clinical psychologists and social workers cannot bill for psychotherapy services that include medical evaluation and management services.)<sup>51</sup> This list excludes care professionals who may provide valuable services to seriously ill patients in need of care but who have difficulty accessing that care through in-person means.



Individuals with serious illness require patient-centered care that is often best provided by care professionals outside of the list covered by Medicare. Practitioners who support patients with serious illness, but who are not currently covered, may include certified or licensed diabetes educators, respiratory therapists, occupational therapists, physical therapists, and others.

More clinical evidence is needed to assess the impact of different modalities of telehealth on different conditions, on health outcomes, and on quality of care. Demonstrations, such as the expansion of reimbursable health care professionals, can be employed to supplement the gap in a comprehensive evidence base. Lack of this evidence base is often cited as a barrier to eliminating or reducing restrictions associated with reimbursement of telehealth services under Medicare FFS. Additionally, more evidence is needed on the potential for telehealth to reduce health spending while maintaining or improving the quality of care.

Researchers, including those supported by the Agency for Healthcare Research and Quality, the Patient-Centered Outcomes Research Institute, and other non-profit organizations such as the National Quality Forum, have published studies regarding health outcomes and patient experience associated with telehealth services, but there have been few studies focused on cost. A majority of commercial health plans now cover telehealth services, providing another opportunity to expand the evidence base. Implementation of the BBA is expected to considerably increase the number of MA beneficiaries who receive telehealth services, offering a significant opportunity to expand the evidence base. CMS can use its current regulatory tools and authority to further expand the evidence base and inform decision making regarding coverage under Medicare FFS.

## Ensuring Opportunities in Medicare Advantage

### RECOMMENDATION

In developing the listing of the types of telehealth services that are eligible for inclusion in the MA plan basic benefit packages, Congress should direct the HHS secretary to provide flexibility in implementation, take a broad approach to coverage, allow for the full scope of practice in each state, and minimize compliance burdens on providers. Additionally, the secretary should encourage efforts to collect data and update quality measure specifications.

### BACKGROUND

Beginning in 2020, MA plans may offer additional, clinically appropriate telehealth benefits in their annual bid amount beyond the services that currently receive payment under Medicare Part B. This portion of the BBA creates an opportunity for the HHS secretary to implement the MA provisions and define what “additional telehealth benefits” and “clinically appropriate” mean. Taking a broad approach to MA implementation, particularly as it relates to the needs of those with serious illness, would mean continuing to support patient-centered choice and care. For example, definitions of telehealth services under MA should not reintroduce limitations related to the originating site, store and forward use, and the types of providers, as referenced in previous recommendations. Implementation of these MA provisions provides a good opportunity to collect data and grow the needed evidence base of benefits of telehealth for Medicare and its beneficiaries.

## Ensuring Opportunities with Accountable Care Organizations

### RECOMMENDATION

As ACOs expand coverage for telehealth, direct the HHS secretary to assure that determination of services not be unnecessarily restrictive, to support the needs of those with serious illness.

## BACKGROUND

Beginning in 2020, some ACOs can use the Next Generation ACO telehealth waiver, which waives geographic location restrictions and allows a patient's home to serve as an originating site. The waiver can be used in the MSSP Track II, MSSP Track III, and other two-sided risk ACO models with prospective assignments that are tested or expanded through CMMI. This provision would ensure that MSSP and ACO providers are only allowed to furnish telehealth services as currently specified under Medicare's physician fee schedule, with limited exceptions. The law requires that no payment be made for such services that are inappropriate to furnish in the home setting, such as services that are typically furnished in inpatient settings such as a hospital.

With the secretary's guidance, ACOs will appropriately determine whether services that are "inappropriate to furnish in the home" are truly those services that must be furnished in an inpatient setting—such as a hospital—for patient safety reasons. Such determinations must not be unnecessarily restrictive (for example, include routine visits and follow-up) and should support the needs of those with serious illness.



# Medicaid Reimbursement for Telehealth

Many state Medicaid plans offer significant coverage for telehealth services, as CMS has not placed the same restrictions on Medicaid as it has for Medicare. States may reimburse for telehealth under Medicaid as long as the service satisfies federal requirements of “efficiency, economy, and quality of care.”<sup>52</sup> States are not required to submit a State Plan Amendment for reimbursement of telemedicine services if they reimburse in the same way and same amount that they would for face-to-face encounters.

Medicaid coverage of telehealth varies across states: Some programs have reimbursement restrictions based on originating site, provider type, and modality. There is great variance among states because of this flexibility, and not all states are using telehealth to the extent allowed.<sup>53</sup>

- 49 states and Washington, D.C., provide reimbursement for some form of live video in Medicaid FFS.
- 15 states provide reimbursement for store-and-forward.
- 20 states provide reimbursement for remote patient monitoring.
- 23 states limit the type of facility that can serve as an originating site.

The Medicaid and CHIP (Children’s Health Insurance Program) Payment and Access Commission, or “MACPAC,” notes that the use “of telehealth in Medicaid may help states address barriers to care, such as insufficient supply of providers, inadequate transportation options, and long distances between patient and provider and associated travel times. It may be particularly helpful to patients in rural and frontier areas and for patients who need behavioral health services but have concerns about confidentiality or stigma.”<sup>54</sup> As with Medicare, evidence on the effectiveness and outcomes of telehealth in Medicaid is mixed and more research is needed.<sup>55</sup> The fact that states provide different levels of coverage creates an opportunity to review and compare the effectiveness of telehealth with the benefits of removing restrictions.

## RECOMMENDATION

CMS should incentivize states to remove reimbursement restrictions by providing guidance or encouragement to states as well as technical assistance through a resource center to support implementation.

## BACKGROUND

Since there is not much federal guidance for, or information on, the implementation and coverage of telehealth services in state Medicaid programs, states may not be using telehealth to the extent allowed. States have placed restrictions on originating sites and types of services, which prevents seriously ill Medicaid beneficiaries from receiving care via telehealth. More evidence is needed, but the variance among states provides an opportunity for study.

CMS encourages states “to use the flexibility inherent in federal law to create innovative payment methodologies for services that incorporate telemedicine technologies,” and several states have incorporated telehealth into their Medicaid programs to benefit seriously ill individuals who are enrolled in health homes, who are using home and community-based services, and who are dually eligible for Medicare and Medicaid.<sup>56,57</sup> By providing additional encouragement, developing technical assistance, and approving waivers, CMS can help states utilize telehealth to support seriously ill people in their Medicaid programs. At the same time, CMS can continue to study the effectiveness of telehealth by taking advantage of the programs already underway in states.

## State Laws and Regulations

There are many policy barriers aside from reimbursement that prevent individuals with serious illness from accessing health care via telehealth. In the United States, the practice of medicine is regulated state by state. Each state's medical practice act establishes rules for licensing, provision of care, discipline, prescribing, and scope of practice. Additionally, states have different guidelines and governing bodies for each of the different health care professionals. Licensing and prescribing requirements in some states are more restrictive than in others, which prevents certain providers from offering telehealth across state lines if they are not licensed in that state. Obtaining a license in multiple states can be burdensome and prevents some providers from filling workforce shortages. As telehealth usage grows and states remove licensing restrictions, it is important to ensure that the proper standards of care remain so that patients are protected from harm.

### Promoting State Licensure Compacts

#### RECOMMENDATION

The HHS secretary should incentivize states to comply with various licensure compacts through guidance, encouragement to states, or the provision of technical assistance through a resource center to support implementation.

#### BACKGROUND

When telehealth is provided from a clinician to a patient, the encounter is considered to have taken place at the physical location of the patient, not of the clinician. This means that providers are required to meet the laws and regulations of the state where the patient is located, which may include the need for a full or partial license in that state. Obtaining licenses in multiple states can be costly and burdensome to the provider and can prevent patients with serious illness from receiving needed care.

To address this, physicians, nurses, and physical therapist state regulatory boards have developed interstate licensing compacts to ease the burdensome licensure process. Twenty-nine states have enacted the enhanced Nurses Licensing Compact (eNLC), which allows a nurse with a license in a compact member state to practice in another compact member state without having to obtain another state license. The Interstate Medical Licensure Compact has been adopted in 22 states and allows a physician (a medical doctor or an osteopathic doctor, depending on the board in each state) to use an expedited process to obtain a license in a compact member state. Eighteen states have adopted the Physical Therapy Compact, allowing physical therapists and physical therapist assistants to work in a member state without having to obtain another state license.<sup>58</sup> While interstate compacts have increased, many states have yet to adopt this process, preventing health professionals from providing care to the people who many need it the most.

These compacts respect the standards and requirements of each state but allow for clinicians to obtain licenses and provide care to patients in a less burdensome and costly way. Interstate licensure compacts have increased the number of clinicians who can provide care, including via telehealth, across state lines. For example, the Nurse Licensure Compact, a precursor to the eNLC, removed the licensure barrier to telehealth practice for more than 4 million nurses.<sup>59</sup>

Having more providers able to practice across state lines can help fill workforce shortages and provide greater access to patients who have difficulty traveling to receive care.



## Promoting Standard of Care Guidelines

### RECOMMENDATION

The HHS secretary should promote adoption of consensus guidelines for evaluating the appropriate standards of care among state medical boards. Examples of standards include establishing a clinician-patient relationship prior to treatment, documentation of evaluation and patient history, patient-informed consent, continuity of care and referral for emergency services, and meeting both state and federal privacy standards.

### BACKGROUND

As telehealth use increases and technology changes, standards are needed to ensure patients receiving care via telehealth are receiving the same standard of care as they would for an in-person encounter. As mentioned above, there is a need for greater study of telehealth, and this includes impacts on patient safety. A systemic overview of the impact of telehealth on the quality and safety of care found that while the amount of evidence on the cost of telehealth and its impact on health outcomes has grown, the overall impact of telehealth on patient safety is less known.<sup>60</sup> To protect patient safety as telehealth demand and use grows, several organizations that support state medical boards have developed regulatory guidelines so that clinicians can ensure that they are meeting the same standard of care while using telehealth that they would during an in-person encounter.

Many of the regulatory guidelines developed by these organizations have already been adopted throughout the states. For example, in 2014 the Federation of State Medical Boards published *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, which “provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies.”<sup>61</sup> The American Academy of Ambulatory Care Nursing has also developed standards with their *Telehealth Nursing Practice Administration and Practice Standards*, which “articulates expectations for nurses engaged in telehealth practice, and has published revised versions on a regular basis.”<sup>62</sup> These guidelines and standards will help both state regulatory agencies and individual providers meet the appropriate standard of care when providing telehealth services to patients.

### Prescribing

### RECOMMENDATION

The HHS secretary should incentivize states to develop rules on prescribing via telemedicine or telepharmacy by providing guidance to states on model rules and providing technical assistance through a resource center to support states with implementation.

### BACKGROUND

One challenge that emerges with the state-based system of medical practice is prescribing. Both the federal and state governments regulate prescribing based on telehealth encounters. The Ryan Haight Online Pharmacy Consumer Protection Act and Prescribing Controlled Substances, signed into law in 2008, amended the Controlled Substances Act (CSA) by defining legally permissible activities for physicians prescribing controlled substances over the internet. Under the law, the Drug Enforcement Agency has jurisdiction over controlled substances prescribed via telehealth

(“telemedicine” is the term used in the law). There are several situations in which a prescription can be made via telehealth:

- The patient is being treated by and physically located in a hospital or clinic registered to distribute under CSA;
- The patient is being treated by and in the physical presence of a practitioner registered to distribute under CSA;
- The telehealth practitioner is an employee or contractor of the Indian Health Service;
- The telehealth practitioner has obtained a special registration from the U.S. attorney general; or
- The telehealth encounter is being conducted during a medical emergency.

States have control over telehealth prescribing outside of the boundaries of the Ryan Haight Act. As with other components of telehealth, laws and regulations for prescribing vary across states. Both pharmacy and medical state boards require the establishment of a patient-provider relationship in order for physicians to write and pharmacists to fill prescriptions. However, states vary in how they define a patient-provider relationship. Some states require that a physical exam be administered prior to a prescription being written, and some specifically allow the use of telehealth to conduct the exam.<sup>63</sup> Most states explicitly prohibit prescribing or dispensing based solely on an online questionnaire, consultation, phone call or email.<sup>64</sup>

If a patient with serious illness is receiving care via telehealth but cannot receive an appropriate prescription as a result of that encounter, then they are not receiving the spectrum of care that they need. States are continuing to develop policy around telehealth prescribing, but additional guidance is needed to protect patients from harm and to ensure they are receiving much-needed care.

The growing reach of the internet as well as the opioid crisis requires states to be more responsive to telehealth prescribing rules. Several states now explicitly allow for the prescribing of controlled substances through telehealth, within the limits of the CSA. This is in response to the opioid epidemic and the growing need to prescribe certain medications as part of medication-assisted therapy.<sup>65</sup> Guidance from the federal government could help states learn from each other and more rapidly respond to the changing needs of patients.



## Telehealth Access and Training

Even if the legal and regulatory recommendations above are adopted, there are still barriers to accessing telehealth for individuals with serious illness. Clinicians cannot provide, and patients cannot receive, care via telehealth if the infrastructure, including broadband, does not exist or is cost-prohibitive. While this barrier is greatest in rural areas, patients in suburban and urban areas may also lack both wired and wireless broadband.<sup>66</sup> For more than a decade, federal programs have sought to speed up the deployment of broadband and close what is commonly referred to as the “digital divide,” more limited broadband access and use among low-income Americans. Despite providing billions of dollars in grants and loans, the progress made to date is insufficient; home broadband adoption seems to have plateaued—about 65 percent of Americans have broadband access at home. That number drops to 58 percent for residents of rural communities and 45 percent for households with incomes under \$30,000 a year.<sup>67</sup>

Even with the appropriate infrastructure, clinicians face challenges in providing telehealth. The technology has moved rather quickly, and telehealth laws and regulations have lagged. While some graduate and continuing medical education programs are addressing telehealth best practices, clinicians continue to need additional training to provide the best care to high-need patients such as those with serious illness.

## Expanding Broadband Access

### RECOMMENDATION

Federal agencies should streamline and expand grants, loans, and loan guarantees for telehealth services. Grants that should be evaluated and potentially streamlined and expanded could include:

- U.S. Department of Agriculture’s Rural Utilities Service Grants—including the Rural Broadband Access Loan and Loan Guarantee Program, the Community Connect Grant Program, the Telecommunications Infrastructure Loan and Loan Guarantee program, and the Distance Learning and Telemedicine grant program;<sup>69</sup>
- U.S. Department of Commerce’s National Telecommunications and Information Administration’s Broadband Technology Opportunities Program, which is designed to help bridge the technological divide and improve health care;
- Federal Communications Commission’s programs, which include the Connect American Fund, Universal Service Schools and Libraries Program, and the Rural Health Care Program; and
- Universal Service Administrative Company’s Healthcare Connect Fund, which currently has regulatory limitations on the reimbursement amounts that certain large non-rural hospitals may receive for universal service support.

### BACKGROUND

Lack of broadband access prevents clinicians from providing care to patients and prevents patients from receiving care via telehealth. Improving and expanding access has the potential to fill workforce shortages and increase the availability of care for vulnerable populations, especially in rural areas. In addition to demand from patients and providers, many policymakers have seen the upside of a more connected America. In fact, there has been broad, bipartisan support for broadband investment. Yet, finding the right approach for public investment in the space has been a challenge. Key political questions linger:

- Should funding be available to help both the unserved and underserved?
- How can the federal government both support competition but not subsidize overbuilding?
- What standards and technologies should broadband systems include?
- Which federal agency is best suited to make these investments?

Policymakers at all levels of government would benefit from a national strategy to further broadband deployment and connectivity that addresses these key questions. BPC's Executive Council on Infrastructure is building a national strategy with input from a variety of stakeholders.<sup>68</sup> In the interim, additional resources should be provided to support programs and grants that have improved broadband access for patients and providers. As a national strategy to further broadband deployment and connectivity is desirable, but unlikely in the short term, federal programs that support connectivity for health care should be supported and streamlined to allow full access to telehealth services.

## Training providers

### RECOMMENDATION

The HHS secretary should build upon current efforts—such as the Office for the Advancement of Telehealth's Telehealth Resource Center Grant Program—that support the development and dissemination of evidence-based best practices and tools to support clinicians' provision of telehealth services, including addressing changes in clinical workflow, facilitating care coordination, providing team-based care, supporting patient-centered care, and offering other opportunities.

### BACKGROUND

As the demand for telehealth increases, providers need education and training on evidence-based telehealth best practices. Clinicians acknowledge the potential for telehealth, and while many are adopting it into their practice, others cite lack of training as a barrier. Not all preprofessional programs for health care students include formal training related to telehealth, which leads many providers to either not practice telehealth or to try to obtain the necessary training for telehealth on the job.<sup>70</sup> For example, telehealth education requirements have not been outlined in nurse practitioner education, leaving the decision to train, and with what type of training, up to the practitioners themselves, their employers, or individual schools.<sup>71</sup>

Physicians face similar training challenges. The Association of American Medical Colleges found that only 84 medical schools (about 58 percent) included telemedicine as a topic in required or elective courses during the 2016–2017 academic year.<sup>72</sup> The American Medical Association noted that formalized telemedicine training is not widely offered to physicians-in-training and encouraged “the accrediting bodies for both undergraduate and graduate medical education to include core competencies for telemedicine in their programs.”<sup>73</sup> A survey of family physicians found that 56 percent of those not currently using telehealth cited training as a barrier. The survey also found 41 percent of those currently using telehealth still identified training as a barrier to greater use.<sup>74</sup>

The Telehealth Resource Center (TRC) program awards grants that support the “establishment and continued operation of resource centers to assist health care organizations, networks, and health care providers in implementing cost-effective telehealth programs to serve rural and medically underserved areas and populations.”<sup>75</sup> There are currently 12 regional TRCs and two national TRCs that divide their focus between policy and technology. The Consortium Telehealth Resource Center provides information on who offers telemedicine training, which programs are available, and how programs can assess whether a given training program will meet their needs. They have also shared guidelines on developing a training strategy, with information on who needs to be trained and what topics should be covered in that training.<sup>76</sup>

Universities, medical specialty societies, professional associations, non-profits, and private companies provide quality education and training. Nevertheless, a more focused approach with support from the HHS is needed to ensure providers have access to and receive the appropriate, evidence-based training on providing care for patients with serious illness. As the first generation of digital natives enter the health care profession, there is a great opportunity to improve telehealth training with evidence-based best practices that will provide the highest standards of care to patients with serious illness.



# Conclusion

While Congress and the administration have acted to improve the availability of non-medical health-related services for individuals enrolled in MA and ACOs, it will be important to track CMS implementation and whether plans take advantage of the new flexibility. Additional care models should be adopted and evaluated to determine whether these models improve quality and lower costs. Indeed, many of the non-medical health-related services shown to improve patient satisfaction, quality of life, and reduce health care expenditures do not fit squarely within the traditional medical care delivery model and do not necessarily need to be provided by licensed medical professionals. Successful care models provide services, both medical and non-medical health-related, as part of an individualized care plan developed collaboratively by a care team, patients, and family members or caregivers.



*Many of the non-medical health-related services shown to improve patient satisfaction, quality of life, and reduce health care expenditures do not fit squarely within the traditional medical care delivery model and do not necessarily need to be provided by licensed medical professionals.*

Despite recent changes through the BBA and new approaches to the delivery of care for patients with serious illness, the vast majority of individuals with serious illness remain in Medicare FFS. This is especially true in rural areas, where FFS is often the only option. This report seeks to address some of the cost-sharing and care coordination issues in FFS to help improve care coordination for patients with serious illness who are not enrolled in alternative payment models.

Furthermore, increased use of telehealth has the potential to provide greater access to care for people with serious illness. Barriers to increased utilization of telehealth include reimbursement, state licensure requirements, training for clinician, and broadband access for underserved patients. Policymakers have a variety of options to address these barriers, and actions should continue to focus on evidence-based solutions that do not increase costs for patients or the federal government.

Collectively, BPC's leaders believe that the steps recommended in this report can help advance care for those with serious illness. At the same time, BPC leaders agree that more can and should be done to improve quality of care and to respect the wishes and values of those with serious illness.

## Next Steps

Barriers to improving reimbursement and referrals for individuals with serious illness exist at both the federal and state levels. Improving care for this population depends on both medical and non-medical providers enabling beneficiaries to stay in their homes or in community-based settings, but there are provider shortages. Shortages are the result of a number of factors, including an aging health care workforce, state licensure laws that do not permit providers to practice to the full extent of their training, and regulatory barriers in Medicare.

One significant problem is that the lack of a comprehensive system of supports places an undue burden on the family and friends of loved-ones. While there are innovative approaches to family involvement, researchers do not yet have sufficient information to develop proactive policy solutions and to understand both the political and state and federal budgetary impact of policies designed to address that burden. Over the years, many policymakers have tried to improve the availability of long-term services and supports for those who need care, but reform for comprehensive long-term services and supports has been elusive.

BPC will continue to explore policy options that would improve care for Medicare beneficiaries with significant frailty and multiple chronic conditions in Part II of this series on serious illness, specifically focusing on these workforce and family caregiver issues.

# Appendix A

## SUPPLEMENTAL BENEFITS IN MA: BPC AND LEVERAGE FINDINGS

### *Supplemental Benefits in MA: Understanding the Baseline*

Standard MA plans are paid a capitated amount based on the total cost of Medicare Part A- and Medicare Part B-covered services incurred by each enrolled beneficiary. MA plans submit bids that equate to each plan's expected per-enrollee cost of covering Part A and Part B benefits. Those bids are then measured against the county-level or regional benchmark that is derived from Medicare FFS per-beneficiary spending.

If the county or regional benchmark exceeds the MA plan's bid, the plan will receive a portion of the difference as a rebate in addition to the bid amount, as a part of the per-beneficiary capitated payment. However, the MA plans are required to use the rebate dollars to provide supplemental benefits, such as reduced premiums or cost-sharing for Part A and Part B services or for coverage of additional benefits that are not covered under Part A or Part B.

Historically, federal rules have required that supplemental benefits be uniformly available to all enrollees. Beginning in plan year 2019, under rules issued by CMS, MA plans will have the authority to target supplemental benefits to patients with multiple chronic conditions, without offering those benefits to all MA enrollees. In 2020, MA plans will have even more flexibility as the agency implements the Chronic Care Act provisions of the BBA.

Although dual-eligible Special Needs Plans (D-SNPs) are themselves MA plans, many D-SNPs are subject to different rules regarding the provision of non-Medicare-covered services and supports, and they are, by design, tailored to Medicare-Medicaid dual-eligible individuals rather than Medicare-only individuals. Unlike MA plans, D-SNPs that meet a high standard of integration and specified performance on quality-based standards are permitted to offer supplemental benefits beyond those currently permitted for MA plans. Program specifics on this supplemental benefit flexibility can be found in BPC's 2017 report *Challenges and Opportunities in Caring for High-Need, High-Cost Medicare Patients*.<sup>77</sup> D-SNPs are required to help coordinate enrollees' Medicaid-covered services and may (but are not currently uniformly required to) have contracts with a state Medicaid agency to accept capitation payments for the coverage of the enrollee's Medicaid benefits.

CMS has published an analysis of supplemental benefits offered through Medicare-Medicaid plans—those D-SNPs that are in the nine states participating in the Financial Alignment Initiative.<sup>78</sup> As noted in the report:

Each MMP [Medicare-Medicaid Plan] is required to cover all Medicare and Medicaid benefits specified in the three-way contracts between CMS, the state, and the MMP. In addition, many MMPs offer supplemental benefits either by requirements in the three-way contracts or at the MMP's discretion. In some cases, MMPs provide supplemental benefits that are enhanced versions of existing Medicaid or Medicare benefits (for example, skilled nursing facility, home health, transportation). In other cases, MMPs offer benefits that are otherwise unavailable through Medicare and Medicaid.

In the report, CMS concluded that all plans in each of the nine states offered at least one supplemental benefit, with the most common including health and wellness services, telecommunication devices and services, over-the-counter items, and reduction in cost sharing for prescription drugs.

### *Analysis of Supplemental Benefits*

To gain a better understanding of the range of supplemental services offered across MA plans, as evidenced by inclusion in publicly available plan documents, BPC contracted with Leverage. This analysis involved pulling together quantitative and qualitative data as well as policy and regulatory materials to better understand and identify the available data that could be used to develop a baseline on current practice, incentives, barriers, and opportunities that may drive carrier decision making about benefit and service plan design. Developing a baseline could be valuable in assessing the impact of the chronic care provisions of the BBA on those with serious illness and their caregivers as it is implemented over the coming years. At the same time, it provides a snapshot of the significant variation in amount, scope, and duration of benefits, as well as the lack of awareness of enrollees as to the availability of supplemental benefits.



Based on previous BPC research and discussions with health plan representatives, BPC expected that most supplemental benefits would be offered by plans to increase enrollment. The results of the Leverage study confirmed that MA plans' use of supplemental benefits were designed to lower patient out-of-pocket costs and also to provide additional benefits designed to increase enrollment, such as hearing and vision services. BPC hypothesized that analysis of MMP and other D-SNPs would be most informative given the limitations imposed on MA plans prior to implementation of the BBA.

BPC asked Leverage to examine available plan material in three states with high MA enrollment—Arizona, California, and Florida. BPC asked them to try to identify the extent to which plans, including D-SNPs, were offering non-medical supplemental benefits. Leverage identified the following benefits that both stakeholders and current literature support for people with serious illness:

1. Caregiver training;
2. Respite care (non-hospice);
3. Home-based medications management assistance;
4. Home-delivered meals;
5. Housing-related issues (such as minor modifications, grab bars, ramps);
6. Non-emergency medical transportation; and
7. Non-durable-medical-equipment assistive devices, such as pendants to call EMS and phone or tablet applications.

MA plans are prohibited from targeting supplemental benefits, with certain exceptions. While plans have the authority to target benefits provided under MA based on medical necessity, carriers and other stakeholders have expressed concerns that the standard did not go far enough to protect carriers from audits and sanctions should two similarly situated enrollees not receive the same services. As expected, the majority of plans offered few, if any supplemental benefits.

## CONCLUSION

MA plans have historically provided supplemental benefits, such as reduced cost sharing, designed to encourage enrollment. As CMS begins to implement provisions of the BBA related to the provision of supplemental benefits, it will be important to include potential benefits in member-level plan documents.

As noted in the CMS report as a limitation, there is significant variation in benefit descriptions from state to state. In addition, it is unclear from plan materials which supplemental benefits are extensions of benefits already provided by state Medicaid programs.

Finally, the lack of visibility and easy access into the details of plans contained in contracts and medical policies at key decision points such as open enrollment is troubling. This opacity is not suited to those with serious illness as the differences between plans could be significant in terms of both financial burdens and access to necessary services. At the very least, plans should be required to make all of their documents available without requiring zip codes and other barriers.

Today, supplemental benefits in those plans that may target them is almost nonexistent. CMS should provide clear guidance to plans about the availability of supplemental benefits.

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# Notes



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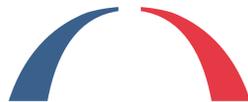
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