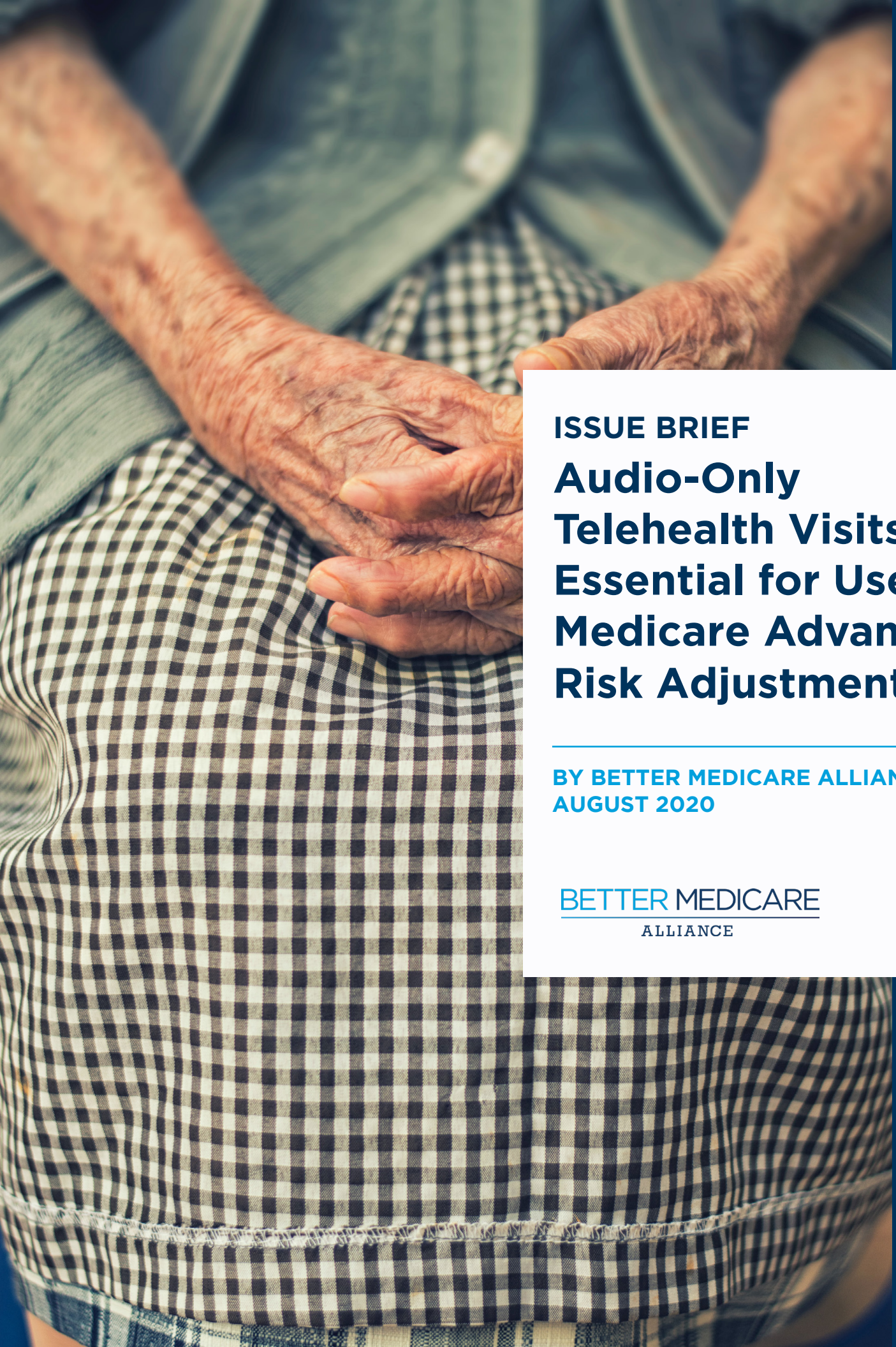


ISSUE BRIEF

Audio-Only Telehealth Visits Essential for Use in Medicare Advantage Risk Adjustment

BY BETTER MEDICARE ALLIANCE

AUGUST 2020

BETTER MEDICARE ALLIANCE

BETTER MEDICARE ALLIANCE

Audio-Only Telehealth Visits Essential for Use in Medicare Advantage Risk Adjustment

ISSUE BRIEF AUGUST 2020

Table of Contents

I. Overview

Medicare Advantage is a public-private partnership where seniors and individuals with disabilities receive Medicare benefits through a private integrated managed care plan. Currently over 24 million beneficiaries are enrolled in Medicare Advantage.[1] Medicare Advantage plans are required to provide beneficiaries with all Part A and Part B benefits. Additionally, Medicare Advantage plans provide additional benefits that are not covered by Traditional Fee-for-Service (FFS) Medicare. These are known as supplemental benefits and typically include dental, vision, hearing, and wellness programs.

The Centers for Medicare and Medicaid Services (CMS) pay Medicare Advantage plans a capitated monthly amount per beneficiary to provide coverage of health care benefits. Risk adjustment is the process that ensures plans receive adequate payment for all beneficiaries, including those with extensive medical needs. This process requires annual individual risk assessments to result in accurate individual risk scores. Those with extensive medical needs receive a higher score, and those with few medical needs receive a lower risk score. Accurate risk adjustment results in adequate payment to plans, and subsequently to providers, to cover all needed care and services for beneficiaries.

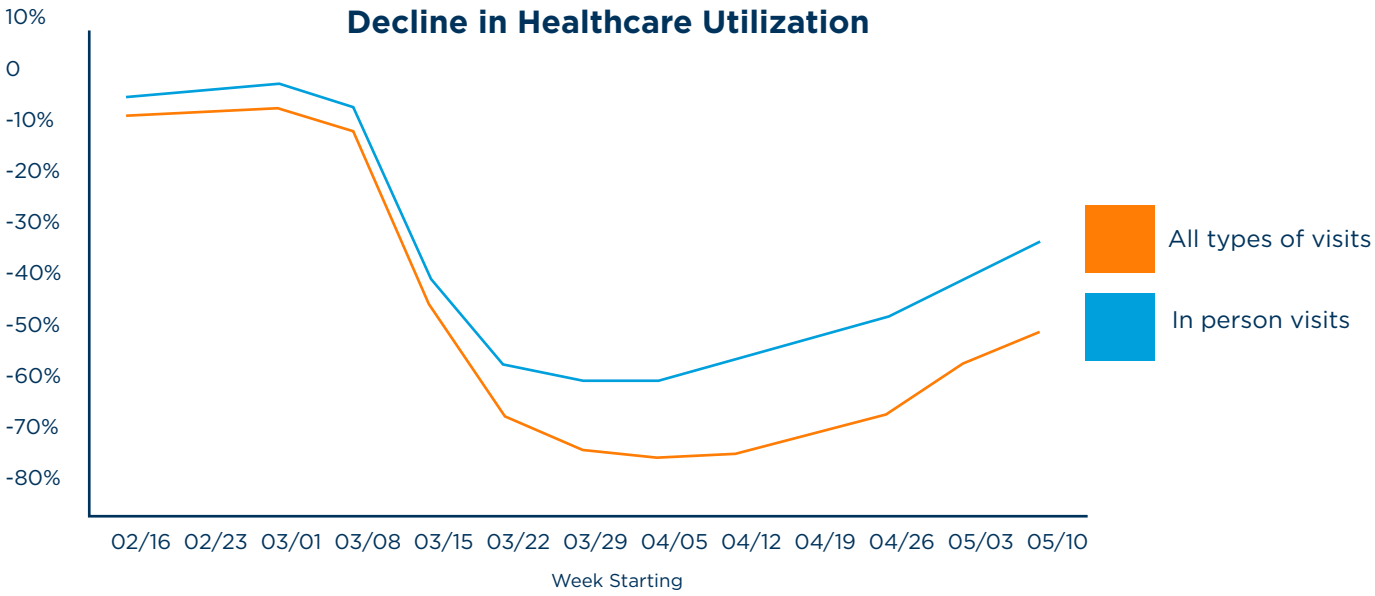
To ensure the capitated payments reflect the health status and demographic characteristics of individual beneficiaries, payment to Medicare Advantage plans is risk adjusted using demographic and diagnostic information. Beneficiary diagnoses are converted to Hierarchical Condition Categories (HCCs). HCCs provide specific information on a patient's medical complexity and HCCs are weighted based on the relative level of risk associated with a condition. There are about 100 HCCs in the Medicare risk adjustment process accounting for numerous chronic conditions.

In Medicare Advantage, risk adjustment is a prospective process required to be done annually for each beneficiary. CMS uses HCCs and other data to calculate the risk score for each beneficiary to predict costs for the upcoming year. For the risk adjustment process to function properly, it is critical to collect data on beneficiaries each year through in-person office visits, telehealth visits, and in-home health risk assessments. Accurate documentation of diagnoses by clinicians is a critical component of the risk adjustment process. It ensures that beneficiaries receive the appropriate care management and quality services based on their conditions.

II. Recent Changes and Impact Due to COVID-19

The Secretary of Health and Human Services declared a public health emergency in response to the coronavirus (COVID-19) on January 31, 2020. As of June 30, 2020, the United States had over 2 million confirmed cases.[2] As a result of the public health emergency and subsequent social distancing policies, health care utilization has dramatically decreased – dropping nearly 70 percent in April (Figure 1).[3] The ongoing emergency and stay at home orders have resulted in delays of in-person clinical care and elective services. One in six older adults have delayed or canceled essential medical treatment.[4]

FIGURE 1.



Source: The Commonwealth Fund

Notes: Data are presented as percentage change in number of visits in a given week from the baseline week (March 1–7). Telemedicine includes both telephone and video visits.

To ensure continuity of care is provided to beneficiaries to help manage chronic conditions and address new or acute conditions, health care providers transitioned to the use of telehealth as a replacement for in-person care. Between mid-March and mid-June 2020, over nine million Medicare beneficiaries have used telehealth services.[5] Between March and April alone there was an increase of more than 11,718 percent in telehealth utilization.[6] Due to the need for telehealth to facilitate continued patient care, CMS has allowed for the use of diagnoses obtained during audio-video telehealth visits to count for risk adjustment. However, CMS has not permitted the use of diagnoses captured via audio-only telehealth visits for risk adjustment. The distinction between the types of telehealth visits inhibits the ability of clinicians to obtain accurate risk adjustment data for submission to CMS.

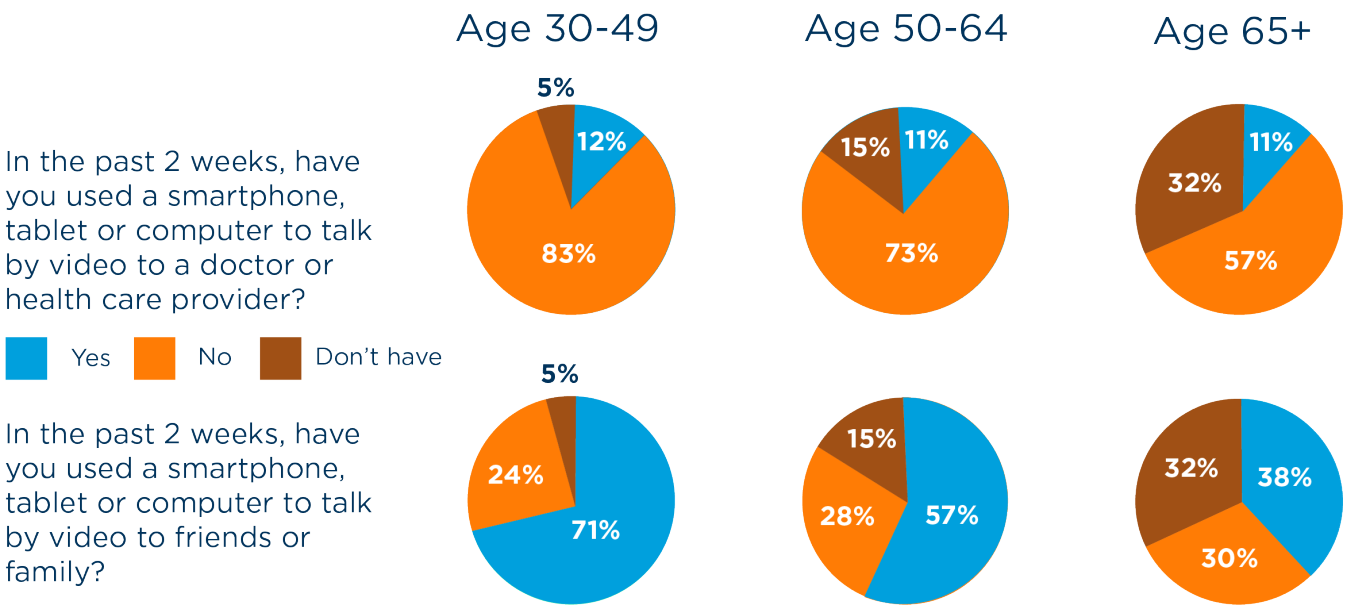
CMS expressed concerns around program integrity and the possibility of a substantial increase in risk scores if diagnoses obtained through audio-only telehealth visits in 2020 are permitted for 2021 risk adjustment. Studies found that risk scores do not usually change significantly year over year. A 2018 Avalere study looked at changes in the HCC model for 2019 and found that risk scores only increased by 0.78 percent, with 79 percent of health plans having an increase in mean risk score ranging from 0.005 to 0.023.[7] A 2020 Avalere study found that Medicare Advantage plans could experience an average decrease in risk scores between 3 to 7 percent from anticipated risk scores prior to the pandemic.[8] Beneficiaries have delayed services to adhere to social distancing guidelines resulting in lower medical claims and fewer opportunities to obtain diagnoses for risk scores. As the pandemic continues its spread, utilization could further drop, and risk scores may decrease by more than 7 percent.[9] The impact on utilization in 2021 is difficult to predict at this point. Potentially deferred care from 2020 could lead to higher health care costs in 2021 due to the worsening of beneficiary health status and fewer visits in 2020. If the pandemic continues into 2021, and older adults and those with comorbidities continue to be advised to stay at home, alternative care delivery including telehealth will continue to be utilized.

III. Challenges

Various challenges limit the use of telehealth among Medicare Advantage beneficiaries. Seven in ten adults 65 and older say they have a computer, smart phone or tablet with internet access at home. While 91 percent of seniors use cell phones, only 53 percent of those are smartphones.[10] Only 11 percent of people 65 and older say they have used a device to talk to a health care provider via video (Figure 2).[11] Meanwhile, a survey of more than 1,000 Medicare Advantage beneficiaries by Morning Consult found that only 24 percent of beneficiaries have accessed telehealth during the COVID-19 pandemic, and nearly one-third of beneficiaries say they are uncomfortable using telehealth.[12] Lack of experience using audio-video technology influence seniors' preference for audio-only. Health care providers are reporting higher usage of audio-only visits compared to audio-video visits. Three million telehealth visits with Medicare beneficiaries between mid-March and mid-June in 2020 were conducted via telephone indicating the preference for audio-only telehealth visits.[13] Security Health Plan and Kaiser Permanente reported 75 percent and 85 percent of their telehealth visits as audio-only, respectively.

FIGURE 2.

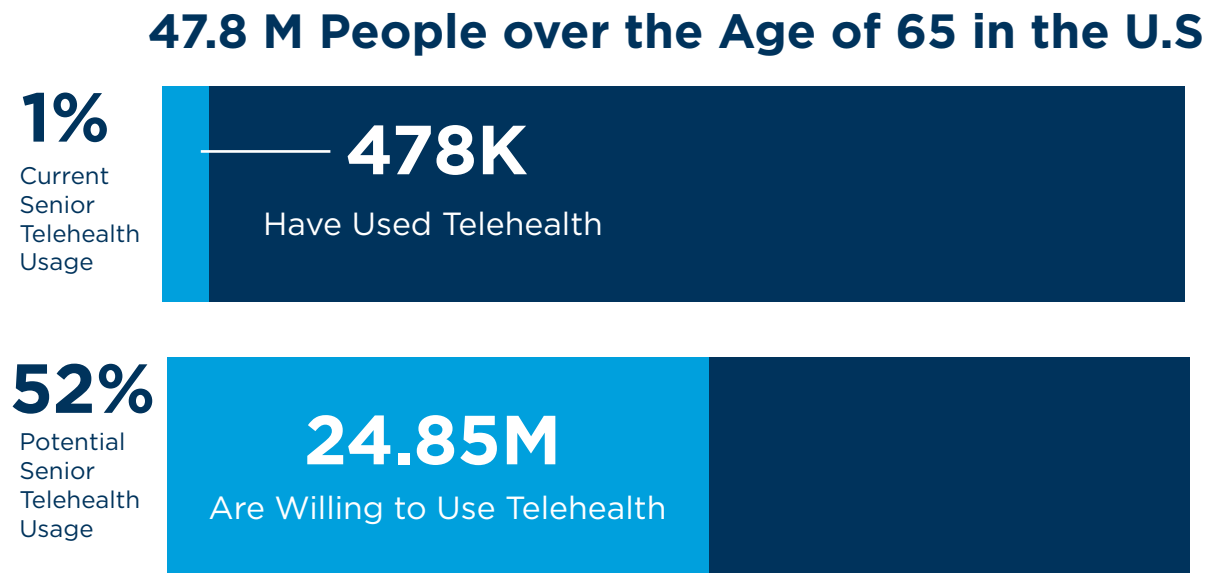
While Most Older Adults Have a Device with Internet Access at Home, Only a Small Share Have Used it to Talk by Video to a Health Care Provider in the Past Two Weeks



Source: KFF Health Tracking Poll (conducted March 25-30, 2020)

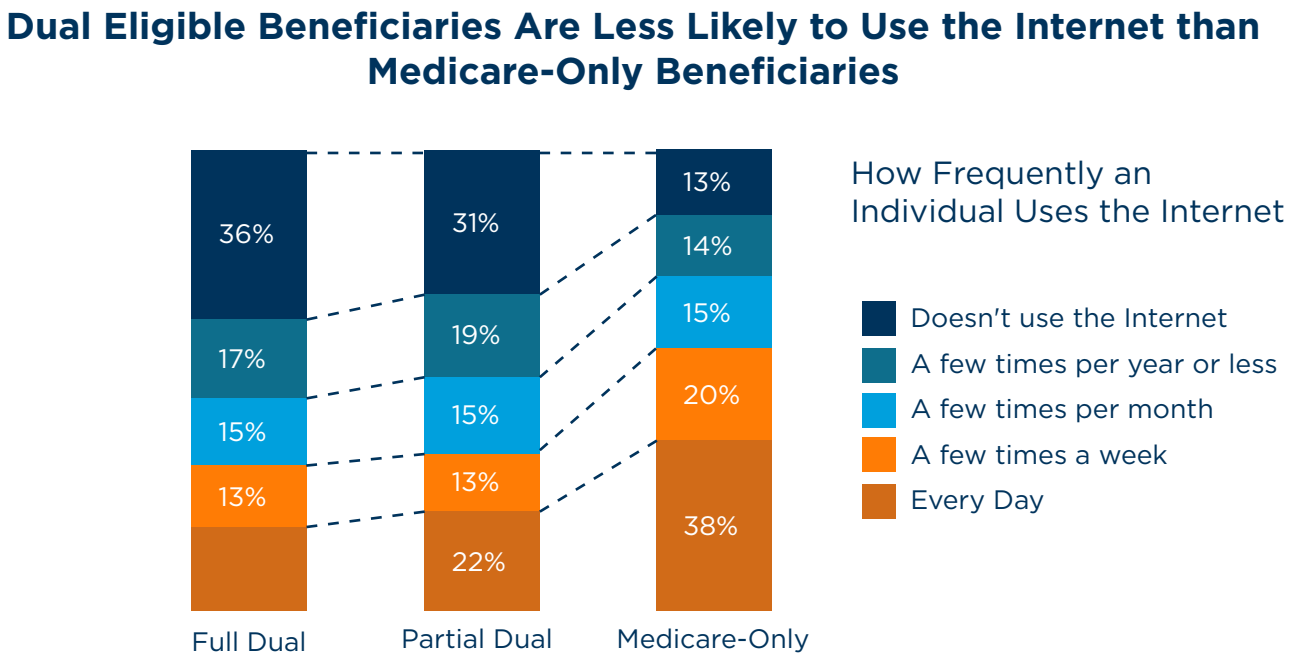
Limited access to the internet also hinders telehealth access. According to the FCC's 2018 Broadband Deployment Report, 24 million Americans do not have access to broadband at the benchmark speed of 25 Mbps/3Mbps. The report also found disparities between rural and urban areas. 68.6 percent of people in rural areas have access to mobile broadband and fixed broadband compared to 97.9 percent in urban areas.[14] An Amwell survey found approximately half of the people over age 65 surveyed were willing to try telehealth but lacked access to the internet (Figure 3).[15] Recently, ATI Advisory found that beneficiaries who have both Medicare and Medicaid, known as dual eligibles, are considerably less likely to use internet than those who only have Medicare coverage. More than half of beneficiaries who are full dual eligible use the internet rarely or not at all (Figure 4).[16] Additionally, some seniors rely on the internet provided in a communal setting, such as a public library or community center. During the ongoing public health emergency, these facilities have been closed or have strict restrictions resulting in limited internet access for certain populations. Beneficiary lack of access to the internet is an obstacle for health care providers required to use audio-video telehealth to assess and document beneficiaries' health status and verify chronic conditions as required for risk adjustment in Medicare Advantage.

FIGURE 3.



Source: Amwell Survey: Telehealth Index: 2019 Senior Consumer Survey

FIGURE 4.



Source: ATI Advisory

Internet accessibility is not the only challenge faced in Medicare Advantage. Beneficiaries with cognitive or functional impairments are often unable to utilize audio-video telehealth technology. Furthermore, many beneficiaries are met with financial constraints and cannot afford to purchase the necessary devices and internet services. According to the Pew Research Center, 18 percent of adults living in a household with an annual income of less than $30,000 are more likely to not use the Internet compared to 2% of adults residing in a home with income of $75,000 per year.[17]

IV. Guardrails

Federal regulators have stated that, even during the pandemic, audio only telehealth should not be used for risk adjustment purposes. There are guardrails on telehealth currently in place to account for program integrity concerns. The guardrails include only permitting specific codes as reimbursable for telehealth services, and only allowing certain providers to bill for telehealth services, such as physicians and nurse practitioners. In addition, guardrails currently in place on telehealth visits being used for risk adjustment include: only using diagnoses obtained during an allowable inpatient, outpatient, or professional service, and the encounter must be a face-to-face visit or audio-video telehealth visit.

CMS believes that additional guardrails are necessary for use of audio-only telehealth visits for risk adjustment to ensure program integrity and prevent an oversized increase in risk scores even during the public health emergency. In response, stakeholders have recommended the following guardrails to obtain diagnoses for risk adjustment through audio-only telehealth visits:

- Permit diagnoses for established patients. Established patients should be defined as patients the clinician or provider group has seen within the last 3 years or is an existing member of the Medicare Advantage Organization. Currently, CMS allows audio-video telehealth to be provided to new and established patients. This would expand the ability to obtain risk adjustment data from beneficiaries who lack access to the internet or have a disability.

- Include diagnoses obtained by a licensed clinician currently allowed to conduct in-home health risk assessments. Including these practitioners ensures that risk assessments are conducted by a clinician with expertise to diagnose a patient's clinical conditions, as well as the knowledge and experience to collect the necessary data for submission to CMS.

- Only count diagnoses obtained when the beneficiary has indicated the preference for an audio-only telehealth visit. Providing patients all their options and having them choose the best way to communicate for themselves ensures that audio-only is being used due to patient need or preference.

- New diagnoses require a documented lab test, other diagnostic test, or fill of a prescription medication. This provides confirmation of the diagnosis and indicates it is clinically verified.

- Limit the use of audio-only for risk adjustment purposes to public health emergencies or natural disasters. This ensures that the use of audio-only telehealth is only used when there are extenuating circumstances making in-person visits unsafe.

V. Conclusion

Seniors are at high risk for COVID-19. According to the Centers for Disease Control and Prevention, eight out of ten COVID-19 deaths are among adults 65 and older.[18] Preliminary data released by CMS, show over 350,000 Medicare beneficiaries were diagnosed with COVID-19 between January 1 and May 16, 2020.[19] As the pandemic continues, audio-only telehealth is an essential tool to provide continuity of care and address medical concerns of beneficiaries. Additionally, it will help Medicare Advantage plans serve beneficiaries with cognitive and functional impairments and seniors facing the digital divide. It is essential that risk adjustment be accurate and stable to ensure adequate resources are available to cover all medical care and services for Medicare Advantage beneficiaries. Therefore, it is recommended that CMS permit diagnoses obtained during audio-only telehealth visits to count towards a beneficiary's risk score when in-person clinical visits are not advisable.

Sources

[1] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Dashboard/Medicare-Enrollment/Enrollment%20Dashboard.html

[2] https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

[3] https://www.commonwealthfund.org/publications/2020/apr/impact-covid-19-outpatient-visits

[4] https://www.npr.org/sections/coronavirus-live-updates/2020/04/28/847607008/survey-1-in-6-older-americans-delayed-or-canceled-medical-care-in-march

[5] https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/

[6] https://www.healthcaredive.com/news/medicare-seniors-telehealth-covid-coronavirus-cms-trump/578685/

[7] https://www.avalere.com/insights/impct-of-cms-changes-to-the-medicare-advantage-risk-asjustment-models

[8] https://avalere.com/insights/how-covid-19-could-reduce-ma-risk-scores-and-payments-in-2021

[9] https://avalere.com/insights/how-covid-19-could-reduce-ma-risk-scores-and-payments-in-2021

[10] https://www.pewresearch.org/internet/fact-sheet/mobile/

[11] https://www.kff.org/coronavirus-policy-watch/possibilities-and-limits-of-telehealth-for-older-adults-during-the-covid-19-emergency/

[12] https://www.bettermedicarealliance.org/news/poll-seniors-give-telehealth-high-marks-medicare-advantage-satisfaction-smashes-new-record/

[13] https://www.healthaffairs.org/do/10.1377/hblog20200715.454789/full/

[14] https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2018-broadband-deployment-report

[15] https://static.americanwell.com/app/uploads/2019/06/Senior-Consumer-Survey-eBook.pdf

[16] https://atiadvisory.com/left-behind-in-the-era-of-internet-yet-another-challenge-facing-dual-eligible-beneficiaries/

[17] https://www.pewresearch.org/fact-tank/2019/04/22/some-americans-dont-use-the-internet-who-are-they/

[18] https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html

[19] https://www.cms.gov/blog/medicare-covid-19-data-release-blog