**Telehealth in the Medicare Fee-for-Service (FFS) Program: Overview and Policy Position**

*Statutory Restrictions under Section 1834(m) of the Social Security Act*

Section 1834(m) of the Social Security Act (42 U.S.C. 1395m) restricts utilization of and reimbursement for telehealth and remote patient monitoring services in the traditional Medicare fee-for-service (FFS) program by narrowly defining conditions around eligibility for coverage. As a result, the benefits offered by these advanced technologies are limited to certain groups of beneficiaries.

A primary limitation is the originating site restriction, which requires the patient receiving the telehealth service to be in specific sites and geographic regions to qualify for Medicare coverage. Generally, covered telehealth services must be provided in rural areas as determined by HHS.

***Policy Impact***

The impact of Section 1834(m) restrictions is far-reaching and widely felt, and will be increasingly consequential with the influx of beneficiaries as baby boomers retire. As a result of Medicare’s existing reimbursement policy:

* No coverage for about 80% of Medicare beneficiaries who live in the 1,200 metropolitan counties not included in the definition of “rural.”
* No coverage for “store‐and‐forward” services (such as transmission of medical images) for the 43 million beneficiaries who live outside of Alaska and Hawaii.
* No coverage for services originating from a beneficiary’s home (even for the “homebound”), a hospice and other common non‐medical locations from which a beneficiary seeks service.
* No coverage for otherwise covered Medicare services of physical therapy, occupational therapy, speech‐language pathology, audiology and some other practitioners.
* No coverage for most health procedure codes, precluding the best judgment of physicians and other practitioners about the medical needs and other circumstances of beneficiaries.

***Reform is Long Overdue***

Partial Medicare reimbursement for telehealth services was authorized in the Balanced Budget Act of 1997 (BBA). The scope of the original policy was then expanded through the Benefits Improvement and Protection Act of 2000 (BIPA), which removed some of the prior constraints, yet maintained significant restrictions on geographic location, originating sites, and eligible telehealth services.

It has been 15 years since policymakers have updated the 1834(m) statute and in that time, advanced technologies have rapidly proliferated and given rise to a revolution in the health care sector. Technological advancements, like videoconferencing, have brought new modalities of health care delivery, extending provider reach and expanding patient access. Patient portals, mobile apps, electronic health records, and remote patient monitoring have unleashed new opportunities for increased transparency and patient engagement.

***Consumer Demand and Marketplace Growth***

At the same time, consumer attitudes and behaviors are evolving. According to a December 2014 survey, the majority of consumers would see a doctor a via a telehealth video consultation. Interest among the millennial generation was highest, with 74 percent young adults 18-34 years old reporting they would use telehealth video consultation. The same survey found that telehealth is preferred to in-person visits in certain instances, with 70 percent of consumers reporting that they’d rather have an online video visit than an in-office visit to obtain common primary care prescriptions. Consumers also indicated interest in telehealth visits for getting prescriptions refilled (60 percent), antibiotics (41 percent), and chronic condition management medication (40 percent).[[1]](#footnote-2)

The growing consumer interest has driven explosive marketplace growth. According to a 2015 report by BBC Research, the telehealth market reached $16.3 billion in 2013 and $19.2 billion in 2014. By 2019, the market is expected to increase to $43.4 billion—which is a five year compound annual growth rate of 17.7 percent.[[2]](#footnote-3)

***Evidence***

The rapid industry growth has generated a growing body of evidence from the commercial marketplace that demonstrates the value proposition of telehealth and proves that when used appropriately, care delivered via telehealth technologies can displace in-person care for a variety of common primary health conditions, such as the flu, sinusitis, urinary tract infections (UTIs), and enhance pre- and post-acute management of chronic conditions, while reducing health care costs and often improving outcomes.

For instance, one recent analysis that combined data from five telehealth providers in the commercial sector and extrapolated the likely impact of telehealth payment on Medicare expenditures found that:[[3]](#footnote-4)

* Despite their convenience, commercial telehealth services are not used excessively. The average number of telehealth visits across vendors was 1.3 visits per patient per year.
* Medicare could realize savings by replacing in-person acute care services with a telehealth visit reimbursed at the same rate as a doctor’s visit. The study found that replacing in-person acute care services with a telehealth visit reimbursed at the same rate as a doctor’s office visit could save the Medicare program an estimated $45/visit.
* “Induced utilization” by those people who use telehealth services instead of forgoing care altogether is unlikely to result in increased total costs to the Medicare program.
* Medicare will only realize losses as a result of making telehealth services available if the percent of Medicare patients using telehealth who would have otherwise “done nothing” increases to more than 32.8%; this is unlikely given that the equivalent proportion is currently 13% in the commercial market.

***A New Baseline***

The existing statutory and regulatory framework hinders providers’ ability to better manage care and treat beneficiaries in less costly care settings and is fundamentally incompatible with the technologies to which it applies. A new baseline is required—one that takes into account the advancements of the last decade, new data and evidence, and the evolving health care ecosystem.

The new baseline eliminates the originating site geographic requirements, lifts restrictions on store-and-forward technologies and expands the list of providers eligible to treat patients via telehealth. The reimagined framework removes these arbitrary parameters and instead focuses on patient outcomes, consistent with the larger paradigm shift value-based case by setting.

1. American Well Press Release, “American Well® 2015 Telehealth Survey: 64% of Consumers Would See a Doctor Via Video.” United States Census Bureau and Harris Poll Data, Harris Poll. Available here: <http://bit.ly/1GIhyVe> [↑](#footnote-ref-2)
2. Mcaskill, Ryan, “Telehealth Market Poised for Multi-Billion Dollar Expansion.” mHealthIntelligence, Feb. 12, 2015. Available here: <http://bit.ly/1B3xd2n> [↑](#footnote-ref-3)
3. Yamamoto, Dale, “Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services.” December 2014. Available here: <http://bit.ly/1wt9gth> [↑](#footnote-ref-4)