U.S. Department of Health and Human Services
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Data Brief
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Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic

Key Takeaways

- Beneficiaries in urban areas were more likely than those in rural areas to use telehealth.
- Dually eligible, Hispanic, younger, and female beneficiaries were also more likely than others to use telehealth.
- Almost one fifth of beneficiaries used certain audio only telehealth services; the vast majority of these beneficiaries used them exclusively.
- Older beneficiaries were more likely to use certain audio only services, as were dually eligible and Hispanic beneficiaries.

Why OIG Did This Review

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries access health care. In response, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries.[1] CMS allowed beneficiaries to use telehealth for a wide range of services and in different locations, including in urban areas and from the beneficiary's home.

In a companion report, OIG found that the use of telehealth increased dramatically during the first year of the pandemic.[2] More than 28 million—about 2 in 5—Medicare beneficiaries used telehealth that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

This data brief expands on that analysis and examines the characteristics of beneficiaries who used telehealth during the first year of the pandemic. This information sheds light on how the temporary expansion of telehealth affected different groups of beneficiaries. This information will help CMS, HHS, Congress, and other stakeholders understand who benefited from the expansion and make decisions about whether some of the temporary changes should become permanent. It can also inform efforts aimed at ensuring that all beneficiaries have appropriate access to telehealth.

This data brief includes beneficiaries in Medicare fee-for-service and Medicare Advantage. This data brief is part of a series that examines the use of telehealth in Medicare and identifies program integrity concerns related to telehealth during the pandemic.[3]

How OIG Did This Review

This analysis focuses on Medicare beneficiaries who used telehealth services during the first year of the pandemic from March 1, 2020, to February 28, 2021. We based this analysis on Medicare fee-for-service claims data, Medicare Advantage encounter data, and data from the Medicare Enrollment Database.

What OIG Found

Beneficiaries in urban areas were more likely than those in rural areas to use telehealth during the first year of the pandemic. Beneficiaries in Massachusetts, Delaware, and California were more likely than beneficiaries in some other States to use telehealth. Dually eligible beneficiaries (i.e., those eligible for both Medicare and Medicaid), Hispanic beneficiaries, younger beneficiaries, and female beneficiaries were also more likely than others to use telehealth. In addition, beneficiaries almost always used telehealth from home or other non-health-care settings. Furthermore, almost one-fifth of beneficiaries used certain audio-only telehealth services, with the vast majority of these beneficiaries using these audio-only services exclusively.[4] Older beneficiaries were more likely to use these audio-only services, as were dually eligible and Hispanic beneficiaries.

What OIG Recommends

As CMS, HHS, Congress, and other stakeholders consider permanent changes to Medicare telehealth services, it is important that they balance concerns about issues such as access, quality of care, cost, health equity, and program integrity. Doing so will ensure that the benefits of telehealth are realized while minimizing risk. The data presented in this report demonstrate how the temporary expansions improved access to telehealth for Medicare beneficiaries during the first year of the pandemic, particularly for those who are medically underserved. Understanding who benefited from increased access and how different groups used telehealth can inform policymakers and stakeholders as they make decisions about telehealth.

Accordingly, we recommend that CMS: (1) take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home, (2) temporarily extend the use of audio-only telehealth services and evaluate their impact, (3) require a modifier to identify all audio-only telehealth services provided in Medicare, and (4) use telehealth to advance health care equity. CMS did not explicitly indicate whether it concurred with our four recommendations.

Primer on: Medicare Telehealth Services During the Pandemic

- **Medicare telehealth services** refer to services that are provided remotely using technology between a provider and a beneficiary.[5]
- The services that can be provided via telehealth include **office visits**, **behavioral health services**, **nursing home visits**, and **home visits**, among others. Most of these services can also be provided in person.
- A group of services known as **virtual care services** is **always provided remotely**.[6] An example of these services is a telephone call with a provider to discuss a beneficiary's medical condition.
- During the pandemic, CMS allowed beneficiaries to use telehealth to access a wide range of services in different locations, including in **urban areas and from the beneficiary's home**. Prior to the pandemic, beneficiaries were allowed to use telehealth only from medical facilities located in rural areas, with a few exceptions.[7]
- During the pandemic, CMS increased the types of services that beneficiaries could use via telehealth, from 118 to **264 service types**.[8]
- During the pandemic, CMS expanded the use of **audio-only** for certain types of telehealth services, such as office visits and behavioral health services. Prior to the pandemic, only audio-video was allowed for the delivery of telehealth services, with a few exceptions.[9]

RESULTS

The COVID-19 pandemic created disruptions in how Medicare beneficiaries accessed health care. Because of concerns about the pandemic, HHS and CMS took a number of actions to provide broader access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services and in different locations, including in urban areas and from the beneficiary's home. Expanding access to telehealth services was intended to help beneficiaries maintain access to needed care while limiting community spread of COVID-19, as well as limiting the exposure to other patients and staff members.

In a companion report, OIG found that the use of telehealth increased dramatically during the first year of the pandemic.[10] More than 28 million—about 2 in 5—Medicare beneficiaries used telehealth that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

This data brief expands on that analysis and examines the characteristics of beneficiaries who used telehealth during the first year of the pandemic from March 2020 through February 2021. It includes beneficiaries in Medicare fee-for-service and in Medicare Advantage. In addition, this analysis looks at billing by individual practitioners but not institutions, such as hospitals.

Understanding the characteristics of beneficiaries who used telehealth during the first year of the pandemic can shed light on how the temporary expansion of telehealth affected different groups of beneficiaries. This information will help CMS, HHS, Congress, and other stakeholders understand who benefited from the expansion and make decisions about whether some of the temporary changes should become permanent. It can also inform efforts that are aimed at ensuring that all beneficiaries have appropriate access to telehealth.

Beneficiaries in urban areas were more likely than those in rural areas to use telehealth

Beneficiaries in urban areas were more likely than beneficiaries in rural areas to use telehealth during the first year of the pandemic.[11] Beneficiaries in urban areas have not historically had access to telehealth. Prior to the pandemic, telehealth services were limited to beneficiaries in rural areas, with some exceptions.[12]

In total, 45 percent of beneficiaries in urban areas used telehealth during the first year of the pandemic. They accounted for more than 24 million of the 54 million Medicare beneficiaries living in urban areas. In contrast, just 33 percent of

beneficiaries in rural areas used telehealth. They accounted for more than 3 million of the more than 11 million Medicare beneficiaries living in rural areas. See Exhibit 1.

Exhibit 1: Medicare beneficiaries in urban areas were more likely than those in rural areas to use telehealth during the first year of the pandemic.

Source: OIG analysis of CMS data, 2022.

Beneficiaries in rural areas may face unique barriers to accessing telehealth. For instance, rural populations are less likely than those in urban areas to have access to broadband connectivity.[13] Rural health care providers may also face challenges providing telehealth to their patients, as equipment and internet connectivity can be expensive.[14]

Beneficiaries almost always used telehealth from home, regardless of whether they lived in urban or rural areas

Almost all beneficiaries who used telehealth during the first year of the pandemic did so from home or other non-health-care settings. Prior to the pandemic, most beneficiaries were required to use telehealth from a health care setting, such as a doctor's office or hospital, with some exceptions.[15]

93%

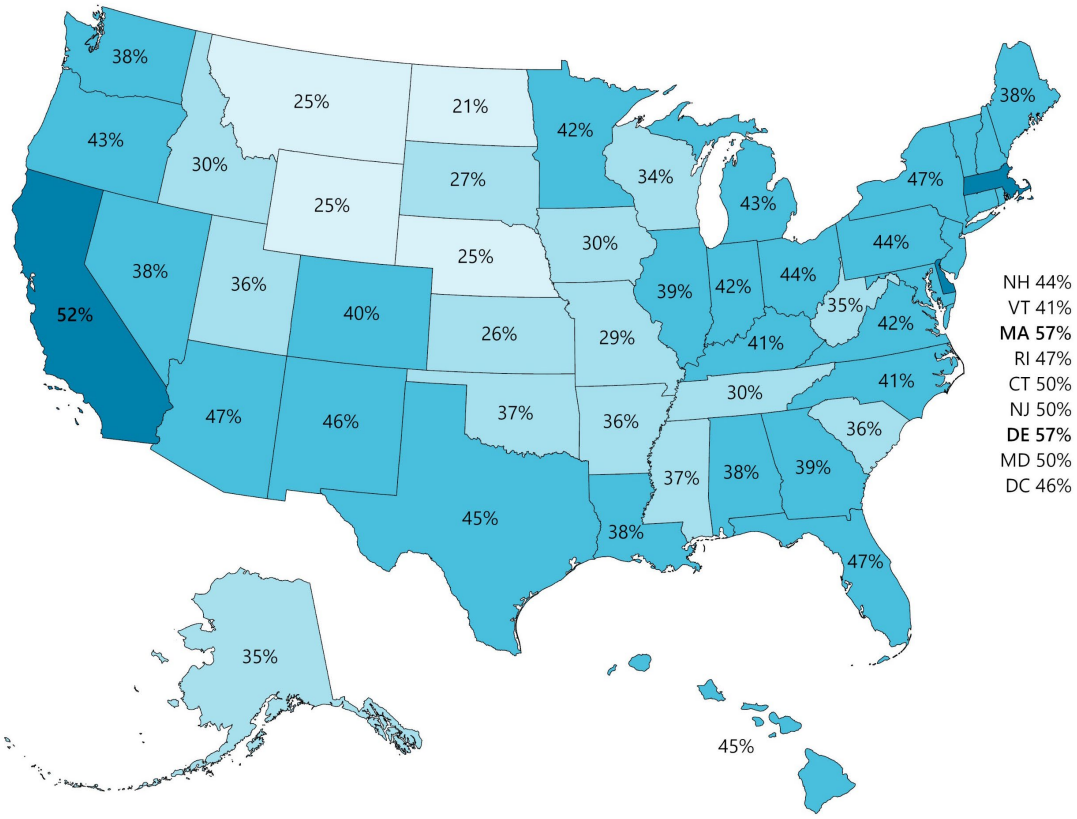
of beneficiaries who used telehealth did so from home or other non-health-care settings.

Beneficiaries in Massachusetts, Delaware, and California were more likely than beneficiaries in some other States to use telehealth

The States with the highest percentages of Medicare beneficiaries who used telehealth during the first year of the pandemic included Massachusetts (57 percent), Delaware (57 percent), and California (52 percent). See Exhibit 2.

This varied greatly from some other States. The States with the lowest percentages of beneficiaries who used telehealth included North Dakota (21 percent), Montana (25 percent), Wyoming (25 percent), and Nebraska (25 percent). See Appendix A for the percentage of beneficiaries who used telehealth in each State.

Exhibit 2: The percentage of beneficiaries who used telehealth during the first year of the pandemic varied by State.



Source: OIG analysis of CMS data, 2022.

Notably, many beneficiaries in these four States live in rural areas. In Montana and Wyoming, roughly two-thirds of Medicare beneficiaries live in rural areas. In North Dakota, more than half of the Medicare population lives in rural areas. In Nebraska, more than 40 percent of all Medicare beneficiaries live in rural areas. As mentioned above, beneficiaries in rural areas may face unique barriers to accessing telehealth.

Dually eligible, Hispanic, younger, and female beneficiaries were more likely than others to use telehealth

To better understand which groups of beneficiaries were more likely than others to use telehealth during the first year of the pandemic, we analyzed the use of telehealth among all beneficiaries enrolled in Medicare and the use of telehealth among those

who used any telehealth-eligible service, either in-person or via telehealth. These measures show the extent to which each group of beneficiaries used telehealth overall and the extent to which each group used telehealth regardless of whether these beneficiaries were more likely to use any service. In this report, we use the term "any service" to refer to any telehealth-eligible service.

For each group of beneficiaries, we found that the likelihood of each group to use telehealth was not impacted by the likelihood of using any service. See Appendix B for detailed information about each group.

Beneficiaries dually eligible for Medicare and Medicaid were more likely to use telehealth than Medicare-only beneficiaries. More than half of all dually eligible beneficiaries used telehealth during the first year of the pandemic. Dually eligible beneficiaries are enrolled in Medicare due to age or disability and in Medicaid due to income. They typically have lower incomes and a higher prevalence of many health conditions than Medicare-only beneficiaries.[16]

In total, 53 percent of dually eligible beneficiaries used telehealth during the first year of the pandemic, compared to 40 percent of Medicare-only beneficiaries. See Exhibit 3. Notably, dually eligible beneficiaries were more likely than Medicare-only beneficiaries to use telehealth regardless of race and ethnicity, and whether they lived in rural or urban areas.

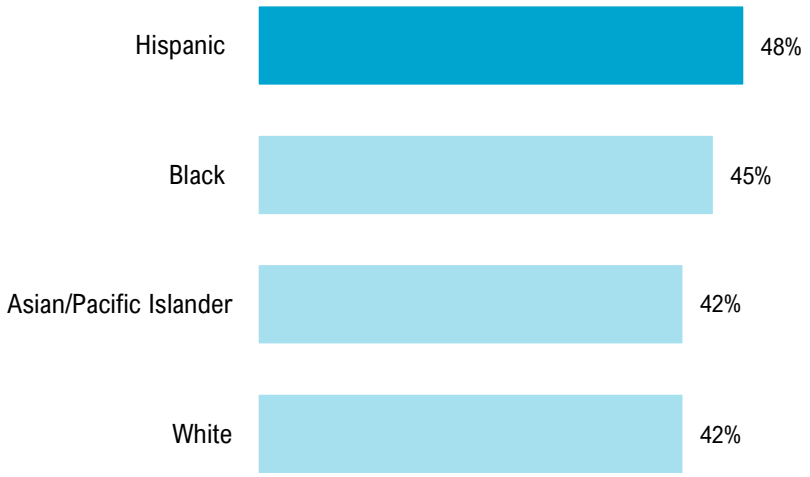
Exhibit 3: Dually eligible beneficiaries were more likely than Medicare-only beneficiaries to use telehealth during the first year of the pandemic.

Source: OIG analysis of CMS data, 2022.

Dually eligible beneficiaries were also more likely to use any service (telehealth or in-person) than Medicare-only beneficiaries; however, this did not appear to explain the relatively high use of telehealth by dually eligible beneficiaries. When accounting for their increased likelihood of using any service, dually eligible beneficiaries were still more likely to use telehealth services than Medicare-only beneficiaries.

Hispanic beneficiaries were more likely than beneficiaries in other groups to use telehealth. Overall, 48 percent of Hispanic beneficiaries used telehealth during the first year of the pandemic, which is a higher percentage than beneficiaries in other racial and ethnic groups.[17] In total, 45 percent of Black beneficiaries used telehealth, while 42 percent of both Asian/Pacific Islander and White beneficiaries did so. See Exhibit 4.

Exhibit 4: Hispanic beneficiaries were more likely than other groups to use telehealth during the first year of the pandemic.



Source: OIG analysis of CMS data, 2022.

It is important to note that Hispanic beneficiaries were more likely to use telehealth than others regardless of whether the beneficiaries lived in rural or urban areas, or whether or not they were dually eligible.

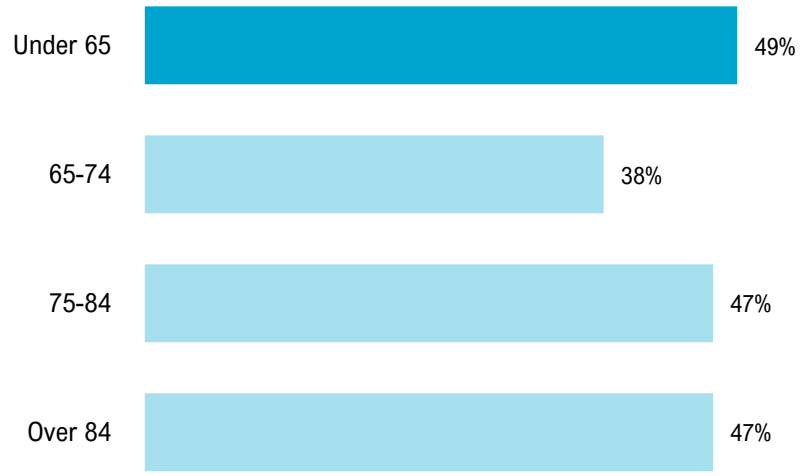
Unlike their use of telehealth during the first year of the pandemic, Hispanic beneficiaries were less likely to use any service (telehealth or in-person) than White beneficiaries and Black beneficiaries. Yet, even when accounting for their decreased likelihood of using any service, Hispanic beneficiaries were still more likely to use telehealth than White beneficiaries and Black beneficiaries. This suggests that Hispanic beneficiaries—a medically underserved population—particularly benefited from the expanded access to telehealth during the first year of the pandemic.

Beneficiaries under age 65 were more likely than beneficiaries in other age groups to use telehealth. Overall, 49 percent of beneficiaries under the age of 65 used telehealth during the first year of the pandemic. These beneficiaries were more likely to use telehealth than beneficiaries in other age groups. Beneficiaries under the age of 65 usually qualify for Medicare because of a disability and are often dually eligible.

Beneficiaries between the ages of 65 and 74 were less likely to use telehealth than other age groups. Specifically, 38 percent of beneficiaries between 65 and 74 used telehealth, while 47 percent of beneficiaries 75 and older did so. See Exhibit 5.

Unlike their use of telehealth, beneficiaries under 65 were less likely than beneficiaries 75 and older to use any service (telehealth or in-person). Yet, even when accounting for their decreased likelihood of using any service, beneficiaries under 65 were still more likely to use telehealth services than beneficiaries 75 and older. This suggests that beneficiaries under 65 particularly benefited from the expanded access to telehealth during the first year of the pandemic.

Exhibit 5: Medicare beneficiaries under age 65 were more likely than other age groups to use telehealth during the first year of the pandemic.



Source: OIG analysis of CMS data, 2022.

Female beneficiaries were more likely than male beneficiaries to use telehealth. In total, 46 percent of all female beneficiaries compared to 39 percent of male beneficiaries used telehealth during the first year of the pandemic. Female beneficiaries were more likely to use telehealth than male beneficiaries regardless of age, race and ethnicity, whether they were in a rural or urban area, or whether or not they were dually eligible.

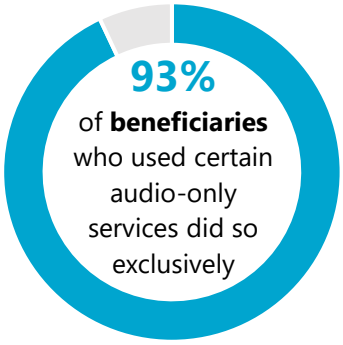
Female beneficiaries were also more likely to use any service (telehealth or in-person) than male beneficiaries; however, this did not appear to explain the relatively high use of telehealth by female beneficiaries. When accounting for their increased likelihood of using any service, female beneficiaries were still more likely than male beneficiaries to use telehealth services.

Almost 1 in 5 beneficiaries used certain audio-only telehealth services; the vast majority of these beneficiaries used them exclusively

Almost 1 in 5 Medicare beneficiaries used certain telehealth services that were available audio-only during the first year of the pandemic. These six audio-only services do not include video. These services consist of telephone calls with a provider for various durations to discuss a beneficiary's medical condition.[18] A total of 12.7 million Medicare beneficiaries, or 19 percent of all beneficiaries, used these audio-only services during the first year of the pandemic.

It is important to note that an additional 86 telehealth services are available either as audio-only or audio-video, but Medicare data do not distinguish between the two.[19] Therefore, the total number of beneficiaries who used any audio-only services during the first year of the pandemic is higher than 12.7 million.

Exhibit 6: The vast majority of beneficiaries who used certain audio-only services did not use any audio-video telehealth services.



Source: OIG analysis of CMS data, 2022.

The vast majority of beneficiaries—93 percent—who used the six audio-only telehealth services did so exclusively. These beneficiaries did not use any audio-video telehealth services during the first year of the pandemic.[20] The remaining 7 percent of beneficiaries used both audio-only and audio-video telehealth services. See Exhibit 6. Using audio-only services exclusively may suggest that these beneficiaries prefer audio-only telehealth services, or that they may face barriers to using audio-video telehealth.

Older beneficiaries were more likely to use certain audio-only services, as were dually eligible and Hispanic beneficiaries

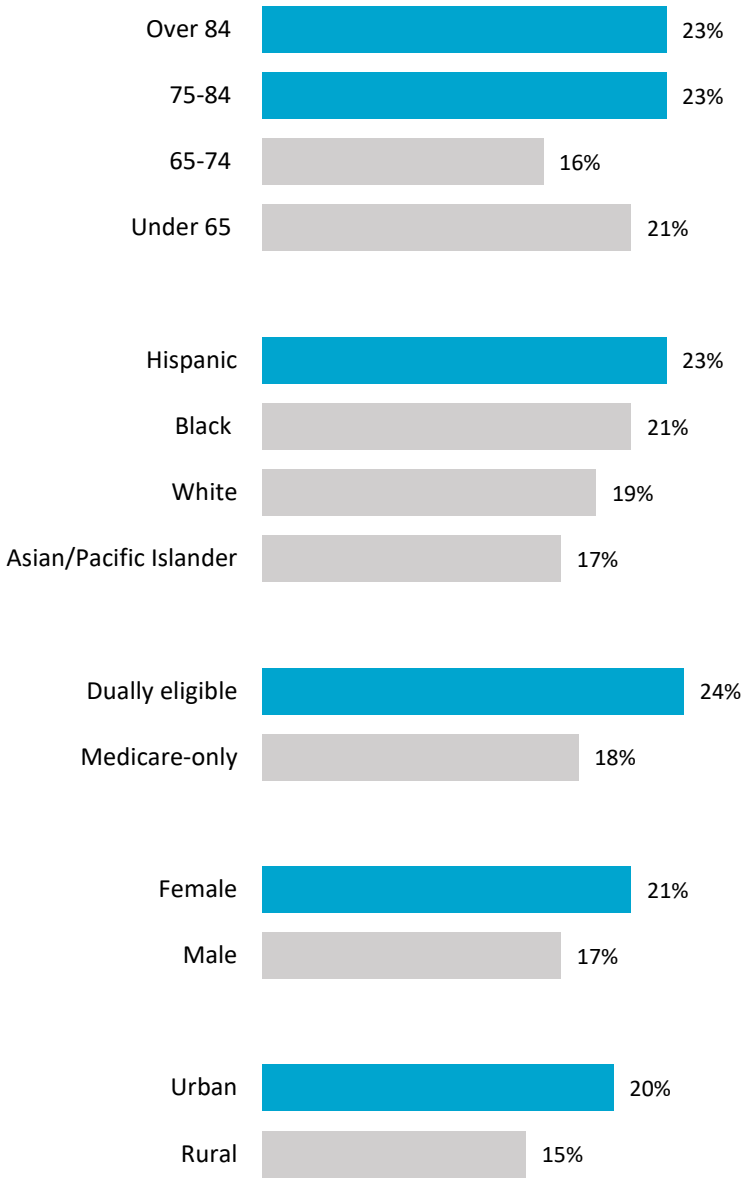
Older beneficiaries were more likely to use the six audio-only services compared to younger beneficiaries during the first year of the pandemic. Specifically, 23 percent of beneficiaries 75 and older used audio-only services, while only 21 percent of beneficiaries under 65 did the same. This pattern is unlike that for all telehealth services and may indicate that older beneficiaries prefer audio-only or have greater difficulty accessing audio-video technology than their younger counterparts. See Exhibit 7.

In addition, dually eligible beneficiaries and Hispanic beneficiaries were more likely to use these audio-only services than other beneficiaries. More than 20 percent of

dually eligible beneficiaries and Hispanic beneficiaries used these audio-only services. Beneficiaries in these groups were also more likely to use all telehealth services.

Furthermore, female beneficiaries were more likely to use these audio-only services than male beneficiaries, and those in urban areas were more likely to use these audio-only services than those in rural areas.

Exhibit 7: Certain beneficiaries were more likely to use these audio-only services than others during the first year of the pandemic.



Source: OIG analysis of CMS data, 2022.
Note: This analysis is based on the six audio-only services.

CONCLUSION AND RECOMMENDATIONS

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, HHS and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries.

In a companion report, OIG found that the use of telehealth increased dramatically during the first year of the pandemic.[21] More than 28 million—about 2 in 5—Medicare beneficiaries used telehealth that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

This data brief expands on that analysis and found that, during the first year of pandemic, many Medicare beneficiaries relied on using telehealth from locations and in ways not previously allowed by Medicare, such as from urban areas, from home, and through audio-only.[22] More specifically, we found that beneficiaries in urban areas were more likely than those in rural areas to use telehealth. Dually eligible beneficiaries and Hispanic beneficiaries were also more likely than others to use telehealth. In addition, beneficiaries almost always used telehealth from home or other non-health-care settings. Furthermore, almost one-fifth of beneficiaries used certain audio-only telehealth services, with the vast majority of these beneficiaries using these audio-only services exclusively.

As CMS, HHS, Congress, and other stakeholders consider permanent changes to Medicare telehealth services, it is important that they balance concerns about issues such as access, quality of care, cost, health equity, and program integrity. Doing so will ensure the benefits of telehealth are realized while minimizing risk. The data presented in this report demonstrate how the temporary expansion improved access to telehealth for Medicare beneficiaries, particularly for those who are medically underserved. Understanding who benefited from increased access and how different groups used telehealth can inform policymakers and stakeholders as they make decisions about telehealth.

We recommend that CMS:

Take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home

Our findings demonstrate the important role that telehealth played in Medicare beneficiaries' access to care when telehealth became more broadly available during the pandemic. This was especially true for beneficiaries in urban areas, as more than 24 million beneficiaries in urban areas used telehealth services from March 2020 through

February 2021. Furthermore, when given the option, more than 90 percent of all beneficiaries (urban and rural) who used telehealth did so from home or other non-health-care settings. Prior to the pandemic, many of these beneficiaries were not allowed to use telehealth in urban areas or from home. However, unless policymakers take action, millions of beneficiaries in urban areas, as well as millions of beneficiaries in both urban and rural areas receiving care from home, will lose access to many telehealth services once the temporary expansions to telehealth end.[23]

Congress has extended the temporary telehealth expansions for 5 months after the public health emergency ends. If that deadline comes before long-term telehealth policies have been enacted, CMS should seek additional authority from Congress to temporarily continue access to telehealth services in urban areas and from the beneficiary's home. This will ensure that beneficiaries enrolled in Medicare fee-for-service can continue to receive services via telehealth, regardless of geographic location or ability to travel to a health care facility to receive care, while policymakers deliberate and develop more permanent policies for telehealth.

As CMS develops proposals for long-term policies on telehealth, it should carefully consider the impacts of telehealth flexibilities on beneficiary access to care, health equity, quality, costs, and program integrity. CMS should take into account the analysis detailed in this brief and consider building on it to further analyze access to care for medically underserved beneficiaries, including how maintaining the availability of telehealth could facilitate access to care for these beneficiaries. CMS should also use other OIG work, including the other report in this series about program integrity concerns related to telehealth, additional analysis it conducts, and feedback and data from other stakeholders as it develops policy proposals.[24]

Temporarily extend the use of audio-only telehealth services and evaluate their impact

CMS should temporarily extend the use of audio-only for telehealth services once the temporary expansions to telehealth end, seeking statutory authority, if necessary. CMS should then evaluate the impact of audio-only services on beneficiary access, equity, cost, quality of care, and program integrity.[25]

During the first year of the pandemic, more than 12 million beneficiaries used certain audio-only telehealth services; the vast majority of these beneficiaries used audio-only telehealth services exclusively. These beneficiaries may prefer audio-only or face barriers to accessing audio-video telehealth services, such as a lack of appropriate technology or broadband access. Furthermore, certain beneficiaries such as older, Hispanic, and dually eligible beneficiaries were more likely to use these audio-only services than other beneficiaries during the first year of the pandemic.

Without further action, Medicare beneficiaries enrolled in Medicare fee-for-service will no longer be allowed to use audio-only services (except in certain circumstances) once

the temporary expansions to telehealth end.[26] In addition, there are questions about the impact of these services on quality of care, among other issues.[27]

CMS should use the information in this brief, information from its evaluations, and feedback and data from other stakeholders to determine whether to permanently expand the use of audio-only services and what, if any, limitations should be placed on these services. For example, CMS could allow audio-only telehealth services solely for providers with whom the beneficiary has an established relationship or when the beneficiary has periodic in-person visits with the provider.[28]

Require a modifier to identify all audio-only telehealth services provided in Medicare

CMS is not able to identify all audio-only telehealth services. Currently, it can identify 6 services, but it is not able to identify whether audio-only services were provided for 86 other telehealth services. Not being able to identify these services when they are provided as audio-only makes it difficult to assess the use of audio-only as well as its impact on access, quality of care, equity, and program integrity.

Starting in 2022, CMS requires that providers use a modifier when billing for audio-only telehealth services under certain circumstances.[29] CMS should build upon this and require providers to use this modifier to identify all telehealth services provided as audio-only.[30] This is important in the event CMS further expands the use of audio-only telehealth on a more permanent basis. CMS should require that providers identify all services that are provided as audio-only so that it can evaluate and monitor the use of audio-only services.

Use telehealth to advance health care equity

Telehealth can be a valuable tool for increasing access to care, especially for certain beneficiaries. We found that dually eligible, Hispanic, younger, and female beneficiaries were more likely than others to use telehealth during the first year of the pandemic. Furthermore, certain beneficiaries, such as Hispanic beneficiaries, were more likely to use telehealth than other groups even though they were less likely to use any service, suggesting they particularly benefited from the expansion of telehealth.

CMS is committed to advancing health equity and has developed a strategy to promote equity across its programs.[31] Telehealth can help increase access to care, especially for beneficiaries who are medically underserved or face barriers to accessing in-person care. CMS should take steps to promote the use of telehealth and use telehealth to address the goals of its health equity strategy, as appropriate. For example, CMS could incorporate telehealth as an action step to help close gaps in access among medically underserved populations.

In addition, CMS should provide additional outreach and education to assist beneficiaries in accessing telehealth, particularly for beneficiaries with limited access to in-person care. For example, CMS could direct its Quality Innovation Network-Quality Improvement Organizations to provide resources that can assist in accessing telehealth as appropriate and include additional information about telehealth in the Medicare handbook (i.e., Medicare & You).

AGENCY COMMENTS AND OIG RESPONSE

CMS did not explicitly indicate whether it concurred with our four recommendations.

In response to our first recommendation to take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home, CMS noted that it has taken steps to implement telehealth policies consistent with changes in legislation, such as expanding the originating sites at which a beneficiary may be located for mental health telehealth services. CMS stated that it will continue to implement policies consistent with its authority, adding that further legislative change may be necessary to implement this recommendation. In response, OIG recognizes that additional legislative action will be necessary for the transition from current pandemic-related flexibilities, and that the President's FY23 Budget supports extending telehealth coverage beyond the public health emergency to study telehealth's impact on utilization of services and access to care. OIG will continue to monitor the implementation of the President's FY23 Budget proposal and its outcomes.

In response to our second recommendation to temporarily extend the use of audio-only telehealth services and evaluate their impact, CMS noted that it established a policy to allow mental health services to be provided via audio-only telehealth in certain circumstances. CMS stated that it will continue to implement policies consistent with its authority and that further legislative change may be necessary to implement this recommendation. In response, OIG recognizes that additional legislation will be needed to temporarily extend the use of audio-only telehealth for most services. OIG also emphasizes that further assessment of the impact of audio-only telehealth services on equitable access to care is critical given OIG's findings on the individuals who were most likely to use audio-only telehealth during the first year of the pandemic.

In response to our third recommendation to require a modifier to identify all audio-only telehealth services provided in Medicare, CMS noted that, in the Calendar Year 2023 Physician Fee Schedule proposed rule, it proposed requiring physicians and other health care practitioners to include a modifier on claims for telehealth services that were provided using audio-only technology. CMS added that it will take feedback from the public comment period, as well as OIG's recommendation, into consideration as it determines appropriate next steps.

In response to our fourth recommendation to use telehealth to advance health care equity, CMS indicated that it continues to evaluate opportunities to advance health equity, drive innovation, and promote good fiscal stewardship for the Medicare program based on the telehealth flexibilities implemented during the public health

emergency, and will continue to implement policies consistent with its authority. CMS added that it provided education to assist individuals with Medicare in accessing telehealth and that it published a Coverage to Care Telehealth Toolkit that includes general information, such as information about the types of care individuals can receive through telehealth. CMS indicated that it will continue to provide education to individuals with Medicare regarding their options for receiving services via telehealth as appropriate. OIG appreciates CMS's efforts and encourages CMS to build upon these efforts by, for example, providing additional outreach and education to assist beneficiaries in accessing telehealth.

We ask that CMS—in its Final Management Decision—provide details on any plans and progress toward implementing our recommendations.

For the full text of CMS's comments, see Appendix C.

METHODOLOGY

We based this data brief on an analysis of Medicare fee-for-service claims and Medicare Advantage encounters for telehealth services from March 1, 2020, to February 28, 2021. These data are similar to the data used in other reports in the series about Medicare beneficiaries' use of telehealth during the first year of the pandemic.[32]

We used the Medicare Part B fee-for-service claims from the National Claims History File and Medicare Advantage encounters from Part C Encounter data. When identifying telehealth services, we reviewed services billed by individual practitioners; we did not review services billed by institutional entities, such as hospitals and nursing homes. We also used enrollment data for Medicare fee-for-service and Medicare Advantage from the Medicare Enrollment Database.

We used these data to identify the characteristics of beneficiaries who used telehealth services in Medicare fee-for-service and Medicare Advantage during the first year of the pandemic.

Beneficiaries Who Used Telehealth

To conduct this analysis, we first identified the services that Medicare approved for telehealth during the pandemic.[33] These services are described using Current Procedural Terminology codes and Healthcare Common Procedure Coding System codes. These codes are included on the claim by a provider for reimbursement purposes.

As part of our analysis, we included virtual care services as a type of telehealth service. These services are also referred to as communication technology-based services. These services are always delivered remotely and include virtual check-ins, e-visits, remote monitoring, and telephone calls with a provider to discuss a beneficiary's medical condition.

We identified the services that were delivered via telehealth using a modifier (i.e., 95, GT, GQ, or G0) or a place of service code (i.e., 02) that indicates the service was delivered via telehealth. We considered the services that did not have any of these modifiers or codes to be delivered in person.[34]

To identify the audio-only services, we focused on the six telehealth services that are available exclusively as audio-only. These six audio-only services do not include video. They consist of telephone calls with a provider for various durations to discuss a beneficiary's medical condition. We did not include the other telehealth services that can be provided as audio-only because Medicare data for these services do not distinguish between audio-only and audio-video use.

Analysis of Characteristics of Beneficiaries Who Used Telehealth

We analyzed the use of telehealth among beneficiaries with different characteristics.

We first examined the use of telehealth among beneficiaries who lived in urban and rural areas. We determined whether a beneficiary lived in an urban or rural area by matching the beneficiary's ZIP code from the Medicare Enrollment Database with a Census Bureau Core-Based Statistical Area (CBSA). We considered a beneficiary to live in an urban area if they resided in a Metropolitan Statistical Area and in a rural area if they resided in a Micropolitan Statistical Area or outside a CBSA.[35]

We also looked at the use of telehealth services among beneficiaries living in different States. We determined a beneficiary's State of residence based on the beneficiary's address. We also determined the extent to which beneficiaries used telehealth from home and other non-health-care settings.[36]

Next, we looked at the use of telehealth among beneficiaries with certain demographic characteristics. We based this analysis on information from the Medicare Enrollment Database. We reviewed the following characteristics:

- Age (Under 65, 65-74, 75-84, Over 84)
- Sex (Male, Female)
- Race and Ethnicity (White, Black, Hispanic, Asian/Pacific Islander)
- Eligibility Status (Dually Eligible, Medicare-Only)

Note that the race and ethnicity information is based on data collected from the Social Security Administration and an algorithm developed by the Research Triangle Institute.[37] This algorithm attempts to improve the quality of the Social Security Administration's data by amending the race data for certain groups based on name and geography, as well as requests made by individuals for certain Government materials to be provided in Spanish.

For each group described above, we calculated the percentage of beneficiaries who used telehealth among all enrolled beneficiaries and the percentage of beneficiaries who used telehealth among those who used any telehealth-eligible service, either in-person or via telehealth (i.e., any service) during the first year of the pandemic.[38] For example, we calculated the percentage of beneficiaries who used telehealth among all enrolled Medicare beneficiaries in each age group during the first year of the pandemic. We then compared these percentages to determine which age groups were more likely to use telehealth during this time period. For each age group, we then calculated the percentage of beneficiaries who used telehealth among beneficiaries who used any service to determine the extent to which each group used telehealth, regardless of whether they were more likely to use any service.

We conducted a similar analysis of the use of the six audio-only services that are available exclusively as audio-only. For each group, we calculated the percentage of

beneficiaries who used these services among all enrolled beneficiaries during the first year of the pandemic. We then compared these percentages to determine which groups of beneficiaries were more likely to use these audio-only services during this time period. We also determined the extent to which beneficiaries used these audio-only telehealth services exclusively.[39]

Limitations

While this study includes demographic data about those using telehealth services, it is possible that other factors that were not included in this study could have influenced an individual's use of telehealth, such as their diagnoses, health status, or income, among other factors. Understanding how these factors could have influenced the use of telehealth is important for future work.

In addition, although the race and ethnicity information is currently the best available for the entire Medicare beneficiary population, comparisons to self-reported data (available in certain, limited circumstances) show that race and ethnicity are still misclassified for some beneficiaries. As such, we did not report on beneficiaries identified as American Indian/Alaska Native since this group is often misclassified. Furthermore, although Hispanic is an ethnicity, Medicare's data combine race and ethnicity and limit beneficiaries to one category.[40]

Standards

We conducted this study in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

APPENDIX A

Percentage of Beneficiaries in Each State Who Used Telehealth During the First Year of the Pandemic

State	Percentage
Massachusetts	57%
Delaware	57%
California	52%
Connecticut	50%
Maryland	50%
New Jersey	50%
Rhode Island	47%
New York	47%
Arizona	47%
Florida	47%
District of Columbia	46%
New Mexico	46%
Hawaii	45%
Texas	45%
Pennsylvania	44%
New Hampshire	44%
Ohio	44%
Oregon	43%
Michigan	43%
Minnesota	42%
Indiana	42%
Virginia	42%
Kentucky	41%
Vermont	41%
North Carolina	41%

APPENDIX A (Cont.)

State	Percentage
Colorado	40%
Illinois	39%
Georgia	39%
Alabama	38%
Louisiana	38%
Washington	38%
Nevada	38%
Maine	38%
Mississippi	37%
Oklahoma	37%
South Carolina	36%
Utah	36%
Arkansas	36%
Alaska	35%
West Virginia	35%
Wisconsin	34%
Tennessee	30%
Iowa	30%
Idaho	30%
Missouri	29%
South Dakota	27%
Kansas	26%
Montana	25%
Wyoming	25%
Nebraska	25%
North Dakota	21%

Source: OIG analysis of CMS data, 2022

APPENDIX B

Characteristics of Beneficiaries Who Used Telehealth During the First Year of the Pandemic

Exhibit B1: Medicare beneficiaries in urban areas were more likely than those in rural areas to use telehealth.

	Number		*Percentage*	
Area	**Beneficiaries enrolled**	**Beneficiaries who used any service***	**Beneficiaries who used telehealth among those enrolled**	**Beneficiaries who used telehealth among those who used any service**
Urban	54,393,561	44,910,462	**45%**	55%
Rural	11,337,760	9,217,144	**33%**	41%

*This refers to the number of beneficiaries who used any telehealth-eligible service, either in-person or via telehealth.

Source: OIG analysis of CMS data, 2022.

Exhibit B2: Dually eligible beneficiaries were more likely than Medicare-only beneficiaries to use telehealth.

	Number		*Percentage*	
Eligibility	**Beneficiaries enrolled**	**Beneficiaries who used any service***	**Beneficiaries who used telehealth among those enrolled**	**Beneficiaries who used telehealth among those who used any service**
Dually Eligible	12,477,492	11,049,080	**53%**	60%
Medicare-Only	53,605,379	43,079,920	**40%**	50%

*This refers to the number of beneficiaries who used any telehealth-eligible service, either in-person or via telehealth.

Source: OIG analysis of CMS data, 2022.

APPENDIX B (Cont.)

Exhibit B3: Hispanic beneficiaries were more likely than other groups to use telehealth.

	Number		*Percentage*	
Race & Ethnicity	**Beneficiaries enrolled**	**Beneficiaries who used any service***	**Beneficiaries who used telehealth among those enrolled**	**Beneficiaries who used telehealth among those who used any service**
Hispanic	5,744,927	4,472,408	**48%**	61%
Black	7,010,304	5,632,552	**45%**	56%
Asian/Pacific Islander	2,388,933	1,773,416	**42%**	56%
White	48,663,596	40,538,574	**42%**	51%

*This refers to the number of beneficiaries who used any telehealth-eligible service, either in-person or via telehealth.

Note: Information for beneficiaries identified as American Indian/Alaska Native, Other, Unknown, or had missing race and ethnicity data are not included in the table because of limitations with the data. Furthermore, although Hispanic is an ethnicity, Medicare's data combine race and ethnicity and limit beneficiaries to one category.

Source: OIG analysis of CMS data, 2022.

Exhibit B4: Medicare beneficiaries under age 65 were more likely than beneficiaries in other age groups to use telehealth.

	Number		*Percentage*	
Age	**Beneficiaries enrolled**	**Beneficiaries who used any service***	**Beneficiaries who used telehealth among those enrolled**	**Beneficiaries who used telehealth among those who used any service**
Under 65	8,747,663	6,935,246	**49%**	61%
65-74	33,184,295	25,545,589	**38%**	49%
75-84	17,032,153	15,206,898	**47%**	53%
Over 84	7,198,694	6,442,203	**47%**	53%

*This refers to the number of beneficiaries who used any telehealth-eligible service, either in-person or via telehealth.

Source: OIG analysis of CMS data, 2022.

APPENDIX B (Cont.)

Exhibit B5: Female beneficiaries were more likely than male beneficiaries to use telehealth.

	Number		*Percentage*	
Sex	**Beneficiaries enrolled**	**Beneficiaries who used any service***	**Beneficiaries who used telehealth among those enrolled**	**Beneficiaries who used telehealth among those who used any service**
Female	35,849,569	30,514,701	**46%**	54%
Male	30,313,225	23,615,231	**39%**	50%

*This refers to the number of beneficiaries who used any telehealth-eligible service, either in-person or via telehealth.

Source: OIG analysis of CMS data, 2022.

DATE: July 29, 2022

TO: Gregory E. Demske
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Data Brief: Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic (OEI-02-20-00522)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to advancing health equity and recognizes that telehealth may be a useful tool to address disparities. CMS is working to advance health equity by designing, implementing, and operationalizing policies and programs that support health for all the people served by our programs, eliminating avoidable differences in health outcomes experienced by people who are disadvantaged or underserved, and providing the care and support that our enrollees need to thrive.

At the beginning of the public health emergency (PHE), CMS issued waivers to prevent gaps in access to care for patients affected by the COVID-19 PHE, including waivers for services furnished via telehealth. These changes to payment and coverage policies were intended to allow health care providers maximum flexibility to minimize the spread of COVID-19 among Medicare beneficiaries, health care personnel, and the community at large and increase capacity to address the needs of their patients.

On March 17, 2020, CMS announced the expansion of telehealth services on a temporary and emergency basis pursuant to waiver authority added under section 1135(b)(8) of the Social Security Act by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 (Pub. L. 116-123, March 6, 2020). Beginning on March 6, 2020, and for the duration of the COVID-19 PHE, Medicare pays for telehealth services, including office, hospital, and other visits furnished by physicians and other practitioners to patients located anywhere in the country, including in a patient's place of residence. In the context of the COVID-19 PHE, CMS recognized that the use of telehealth could help address new challenges regarding potential exposure risks, for people with Medicare, health care providers, and the community at large. To facilitate the use of telecommunications technology as a safe substitute for in-person services,

CMS, on a temporary interim final basis, added many services to the list of eligible Medicare telehealth services, eliminated frequency limitations and other requirements associated with particular services furnished via telehealth, and clarified several payment rules that apply to other services that are furnished using telecommunications technologies that can reduce exposure risks.[1]

CMS has also taken steps to implement policies consistent with changes in legislation that take effect after the COVID-19 PHE ends. For example, Section 123 of the Consolidated Appropriations Act, 2021 removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder. Section 123 requires for these services that there must be an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service and requires the Secretary to establish a frequency for subsequent in-person visits. CMS implemented these statutory amendments via the Calendar Year 2022 Physician Fee Schedule Final Rule, specifying that an in-person, non-telehealth visit must be furnished at least every 12 months for these services, that exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), while clarifying that more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.[2]

In the Calendar Year 2022 Physician Fee Schedule Final Rule, CMS also established a permanent policy to permit the use of an audio-only interactive telecommunications system for mental health telehealth services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology. CMS also specified that a designated modifier must be used on claims for these services furnished using audio-only communications, which would serve to verify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations.

The Consolidated Appropriations Act, 2022 (Pub. L. 117-103) included several provisions that extend certain Medicare telehealth flexibilities adopted during the PHE for 151 days after the end of the COVID-19 PHE. These include allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, allowing certain services to be furnished via audio-only telecommunications systems, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services.

In the Calendar Year 2023 Physician Fee Schedule Proposed Rule, CMS provided notice of its intent to issue program instruction or other subregulatory guidance to effectuate the changes to telehealth enacted in the Consolidated Appropriations Act, 2022 to ensure a smooth transition

[1] The list of these eligible telehealth services is published on the CMS website at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html.

[2] Medicare Program; Calendar Year 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Final Rule (86 FR 64996) (11/19/2021). Accessed at: https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf

after the end of the PHE.[3] CMS also proposed to extend the time that certain services are temporarily available as telehealth services, which will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list.

CMS continues to evaluate the inclusion of telehealth services that were temporarily added to the Medicare telehealth services during the COVID-19 PHE and evaluate opportunities to implement policies that advance health equity, drive innovation, and promote good fiscal stewardship for the Medicare program based on the telehealth flexibilities implemented during the PHE.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that CMS take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered, long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home.

CMS Response

Section 301 of the Consolidated Appropriations Act, 2022 temporarily expands the scope of telehealth originating sites to include any site in the United States where the beneficiary is located at the time of the telehealth service, including an individual's home, for 151 days after the end of the PHE for COVID-19. CMS has provided notice of its intent to issue program instruction or other subregulatory guidance to effectuate the changes to telehealth enacted in the Consolidated Appropriations Act, 2022 to ensure a smooth transition after the end of the PHE. The President's Fiscal Year (FY) 2023 Budget states that the Administration is committed to supporting a temporary extension of broader telehealth coverage under Medicare beyond the COVID-19 PHE declared by the Secretary to study its ability to promote proper use and access to care.[4]

Additionally, as stated above, CMS has taken steps to implement policies consistent with changes in legislation that take effect after the COVID-19 PHE ends, such as expanding the originating sites at which a beneficiary may be located for mental health telehealth services. In implementing these statutory changes, CMS also established a policy to allow mental health services to be furnished via telehealth using audio-only telecommunications technology in certain circumstances. We will continue to implement policies consistent with our authority, however, further legislative change may be necessary to implement this recommendation.

OIG Recommendation

The OIG recommends that CMS temporarily extend the use of audio-only telehealth services and evaluate their impact.

CMS Response

Section 305 of the Consolidated Appropriations Act, 2022 extends the flexibilities related to furnishing certain telehealth services using audio-only telecommunications technology for 151

[3] Medicare Program; Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Proposed Rule (87 FR 45860) (07/29/2022). Accessed at: https://www.govinfo.gov/content/pkg/FR-2022-07-29/pdf/2022-14562.pdf

[4] Department of Health and Human Services Fiscal Year 2023 Budget in Brief. Accessed at: https://www.hhs.gov/sites/default/files/fy-2023-budget-in-brief.pdf

days after the end of the COVID-19 PHE. The President's Fiscal Year (FY) 2023 Budget states that the Administration is committed to supporting a temporary extension of broader telehealth coverage under Medicare beyond the COVID-19 PHE declared by the Secretary to study its ability to promote proper use and access to care.

Additionally, as stated above, CMS has taken steps to implement policies consistent with changes in legislation that take effect after the COVID-19 PHE ends, such as expanding the originating sites at which a beneficiary may be located for mental health telehealth services. In implementing these statutory changes, CMS also established a policy to allow mental health services to be furnished via telehealth using audio-only telecommunications technology in certain circumstances. We will continue to implement policies consistent with our authority, however, further legislative change may be necessary to implement this recommendation.

OIG Recommendation

The OIG recommends that CMS require a modifier to identify all audio-only telehealth services provided in Medicare.

CMS Response

In the Calendar Year 2023 Physician Fee Schedule proposed rule we proposed that beginning January 1, 2023, a physician or other qualified health care practitioner billing for telehealth services furnished using audio-only communications technology shall append CPT modifier "93" (Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System) to Medicare telehealth claims for those services for which the use of audio-only technology is permitted under § 410.78(a)(3), to identify them as having been furnished using audio-only technology. We will take the feedback received from the public comment period, as well as the OIG's recommendation, into consideration as we determine appropriate next steps.

OIG Recommendation

The OIG recommends that CMS use telehealth to advance health care equity.

CMS Response

CMS is committed to advancing health equity for people with Medicare through operations and policies in the Traditional Medicare, Medicare Advantage and Part D programs, ensuring that services are culturally and linguistically appropriate, care is high-value and person-centered, underserved communities have access to quality care, disparities are eliminated, and social needs are addressed.

As stated above, we continue to evaluate opportunities to advance health equity, drive innovation, and promote good fiscal stewardship for the Medicare program based on the telehealth flexibilities implemented during the PHE and will continue to implement policies consistent with our authority.

CMS has provided education to assist individuals with Medicare in accessing telehealth. For example, CMS has provided information about telehealth to individuals with Medicare in the

Medicare & You Handbook, Medicare.gov, and through social media.[5, 6] CMS has also published a Coverage to Care Telehealth Toolkit which includes general information about types of care individuals can receive through telehealth, how to prepare for an appointment, what to expect during a visit, and more.[7] The Coverage to Care Telehealth Toolkit is available in eight languages. CMS will continue to provide education to individuals with Medicare regarding their options for receiving services via telehealth as appropriate.

[5] Medicare & You 2022. Accessed at: https://www.medicare.gov/media/10991
[6] Medicare.Gov. Accessed at: https://www.medicare.gov/coverage/telehealth
[7] Telehealth: What To Know For Your Family. Accessed at: https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/c2c/consumer-resources

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Acknowledgments

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ENDNOTES

[1] HHS and CMS were able to temporarily expand access to telehealth because of their waiver authority under section 1135 of the Social Security Act, subsequent legislation, and the Secretary's declaration of a public health emergency due to COVID-19. The public health emergency was announced on January 31, 2020. See HHS, *Determination that a Public Health Emergency Exists*, January 31, 2020, accessed at https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx on April 8, 2022. See also Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, accessed at https://www.congress.gov/bill/116th-congress/house-bill/6074/text/rds on November 23, 2021. See also Families First Coronavirus Response Act, accessed at https://www.congress.gov/bill/116th-congress/house-bill/6201/text on April 15, 2022. See also CARES Act, accessed at https://www.congress.gov/bill/116th-congress/house-bill/748/text on November 23, 2021.

[2] OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022.

[3] OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022; OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship,* OEI-02-20-00521, October 2021; OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022; Pandemic Response Accountability Committee, *Telehealth Services in Select Federal Health Care Programs*, OEI-02-22-00150, forthcoming.

[4] These beneficiaries did not use any audio-video telehealth services during this time period. They may have used in-person services.

[5] For the purposes of this report, we refer to the services that can be delivered either via telehealth or in-person—as well as services that are always provided remotely—as telehealth services.

[6] These services are also referred to as communication technology-based services. For the purposes of this report, we refer to them as virtual care services. CMS does not include communication technology-based services in its formal definition of telehealth services.

[7] For example, prior to the pandemic, beneficiaries were allowed to use virtual care services as well as telehealth services to address substance use disorder or end-stage renal disease from home and in urban areas. In addition, beginning in 2020, Medicare Advantage plans were able to allow their beneficiaries to use telehealth services from home and in urban areas.

[8] For the purposes of this study, we included the telehealth services approved for payment by Medicare as of February 28, 2021.

[9] Prior to the pandemic, beneficiaries could receive certain virtual care services, such as virtual check-ins, through audio-only.

[10] OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022.

[11] Beneficiaries residing within a Metropolitan Statistical Area were classified as urban; all others were classified as rural. See the methodology for more information.

[12] Prior to the pandemic, beneficiaries living in urban areas were allowed to use virtual care services as well as telehealth services to address substance use disorder or end-stage renal disease. In addition, beginning in 2020, Medicare Advantage plans were able to allow their beneficiaries to use telehealth services in urban areas.

[13] According to a 2019 report, the Federal Communications Commission estimated that 26 percent of rural residents did not have access to broadband internet service, while 1.7 percent of urban residents also did not have access in 2017. Accessed at https://docs.fcc.gov/public/attachments/FCC-19-44A1.pdf on December 17, 2020.

[14] OIG, *States Reported Multiple Challenges With Using Telehealth To Provide Behavioral Health Services to Medicaid Enrollees,* OEI-02-19-00400, September 2021.

[15] Prior to the pandemic, beneficiaries using telehealth services to address substance use disorder or end-stage renal disease, as well as beneficiaries using virtual care services, were allowed to receive services from home. In addition, beginning in 2020, Medicare Advantage plans were able to allow their beneficiaries to receive services from home.

[16] For more information about how beneficiaries become eligible for both Medicare and Medicaid, see Medicaid and CHIP Payment and Access Commission, *Eligibility: Dually Eligible Beneficiaries*, accessed at https://www.macpac.gov/subtopic/dually-eligible-beneficiaries-eligibility/ on February 22, 2021. For information about the health status of dually eligible beneficiaries, see CMS, *People Dually Eligible for Medicare and Medicaid*, accessed at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MMCO_Factsheet.pdf on December 17, 2020. Also see CMS, *Medicare-Medicaid Coordination Office FY 2019 Report to Congress*, accessed at https://www.cms.gov/files/document/mmco-report-congress.pdf on December 17, 2020.

[17] This analysis uses the race and ethnicity information from Medicare's enrollment database, which is based on data collected from the Social Security Administration and an algorithm. Note that information for beneficiaries identified as American Indian/Alaska Native, Other, Unknown, or that had missing race and ethnicity data are not included because of limitations with the data. Furthermore, although Hispanic is an ethnicity, Medicare's data combine race and ethnicity and limit beneficiaries to one category. Although this information is currently the best available for the entire Medicare beneficiary population, comparisons to self-reported data (available in certain, limited circumstances) show that race and ethnicity is still misclassified for some beneficiaries. In particular, Medicare beneficiaries with a race and ethnicity of American Indian/Alaska Native, Asian/Pacific Islander, or Hispanic are more likely to be misclassified. For further discussion on these topics, see OIG, *Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities*, OEI-02-21-00100, June 2022.

[18] Three of these codes are telephone evaluation and management codes (99441, 99442, 99443) and the other three are telephone assessment and management codes (98966, 98967, 98968).

[19] CMS does not distinguish between audio-only and audio-video for these 86 services. In addition, Medicare Advantage plans can offer "supplemental telehealth benefits" that may include audio-only services that cannot be identified in the data. Furthermore, effective January 1, 2022, CMS will require providers to use a modifier to identify audio-only services for the treatment of certain mental health conditions. See *Medicare Learning Network CY2022 Telehealth Update Medicare Physician Fee Schedule*, accessed at MM12549 - CY2022 Telehealth Update Medicare Physician Fee Schedule (cms.gov) on February 1, 2022. See also 86 FR 64996 (November 19, 2021).

[20] These beneficiaries did not use any audio-video telehealth services during this time period. They may have used in-person services.

[21] OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022.

[22] Prior to the pandemic, there were limited circumstances in which Medicare beneficiaries could access telehealth services in urban areas, from home, and through audio-only.

[23] On November 19, 2021, CMS expanded access to telehealth services to treat mental health conditions for beneficiaries in Medicare fee-for-service. This expansion allows beneficiaries in urban areas and those seeking care from home to access telehealth services that treat mental health conditions. See 86 FR 64996 (November 19, 2021). In addition, the Consolidated Appropriations Act of 2022 extends most telehealth flexibilities for 151 days after the public health emergency expires. See Consolidated Appropriations Act, 2022, accessed at https://www.congress.gov/bill/117th-congress/house-bill/2471 on March 22, 2022.

[24] OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks*, OEI-02-20-00720, September 2022.

[25] This is similar to a recommendation made by the Medicare Payment Advisory Commission. See Medicare Payment Advisory Commission, *March 2021 Report to the Congress: Medicare Payment Policy*, accessed at March 2021 Report to the Congress: Medicare Payment Policy – MedPAC on September 15, 2021.

[26] CMS expanded access to audio-only telehealth services to treat mental health conditions for beneficiaries in Medicare fee-for-service after the public health emergency expires. See 86 FR 64996 (November 19, 2021). The Consolidated Appropriations Act of 2022 also extends the use of audio-only telehealth services for 151 days after the public health emergency expires. See Consolidated Appropriations Act, 2022, accessed at https://www.congress.gov/bill/117th-congress/house-bill/2471 on March 22, 2022.

[27] See Medicare Payment Advisory Commission, *March 2021 Report to the Congress: Medicare Payment Policy*, accessed at March 2021 Report to the Congress: Medicare Payment Policy – MedPAC on September 15, 2021.

[28] Along with its permanent expansion of audio-only telehealth services for mental health conditions, CMS implemented a periodic in-person requirement through which a beneficiary is required to see a provider in person within 6 months prior to their initial audio-only visit and within 12 months for subsequent audio-only visits, with certain exceptions. This in-person requirement applies to audio-video and audio-only telehealth services for mental health conditions. The Consolidated Appropriations Act, 2022 delayed implementation of the required in-person visits until 152 days after the end of the public health emergency.

[29] Effective January 1, 2022, CMS requires providers to use a modifier to identify audio-only services for the treatment of mental health conditions. See *Medicare Learning Network CY2022 Telehealth Update Medicare Physician Fee Schedule*, accessed at MM12549 - CY2022 Telehealth Update Medicare Physician Fee Schedule (cms.gov) on February 1, 2022. See also 86 FR 64996 (November 19, 2021).

[30] The Medicare Payment Advisory Commission, in its *March 2022 Report to the Congress: Medicare Payment Policy*, also recommended CMS require that providers use a claims modifier to identify all audio-only telehealth services. Report accessed at MedPAC March 2022 Report to the Congress on March 22, 2022.

[31] See CMS fact sheet accessed at https://www.cms.gov/files/document/health-equity-fact-sheet.pdf on April 22, 2022.

[32] OIG, *Most Medicare beneficiaries received telehealth services only from providers with whom they had an established relationship*, OEI-02-20-00521, October 2021; OIG, *Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic*, OEI-02-20-00520, March 2022; OIG, *Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks,* OEI-02-20-00720, September 2022.

[33] The codes used in the analysis for this data brief include those on the list available on the CMS website as of February 28, 2021, which can be found at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes. These codes also include the communication technology-based services that were allowed during the first year of the pandemic. See 85 F.R. 19230 (April 6, 2020) and 85 F.R. 84472 (December 20, 2020).

[34] All virtual care service codes were considered as being provided via telehealth as they can only be provided remotely.

[35] CBSAs are comprised of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and non-CBSAs. A Metropolitan Statistical Area is an urbanized area of 50,000 or more people. A Micropolitan Statistical Area is an urbanized cluster of at least 10,000 people but less than 50,000 people.

[36] For this analysis, we reviewed claims submitted by individual professionals and institutions. If a beneficiary's claims did not include an originating site facility fee and the beneficiary had received at least one telehealth service, we considered that beneficiary to have used telehealth from home or a non-health-care setting.

[37] Medicare data combines race and ethnicity and limits beneficiaries to one category.

[38] We determined enrollment based on beneficiaries enrolled in Medicare fee-for-service or Medicare Advantage as of February 28, 2021.

[39] These beneficiaries did not use any audio-video telehealth services during this time period. They may have used in-person services.

[40] For further discussion on these topics, see OIG, *Inaccuracies in Medicare's Race and Ethnicity Data Hinder the Ability To Assess Health Disparities*, OEI-02-21-00100, June 2022.