

## MEDICARE BENEFICIARY USE OF TELEHEALTH VISITS: EARLY DATA FROM THE START OF THE COVID-19 PANDEMIC

During the early days of the Coronavirus disease 2019 (COVID-19) pandemic in the US from March through May 2020, Medicare primary care in-person visits plummeted, but as a result of the flexibilities introduced to address the pandemic, they were partially offset by a substantial increase in telehealth visits. Telehealth visits have continued, even after in-person primary care visits resumed, suggesting continued interest in telehealth for millions of Medicare beneficiaries.

### KEY POINTS

- Medicare fee-for-service (FFS) in-person visits for primary care fell precipitously in mid-March at the start of the COVID-19 public health emergency (PHE), and began to rise again in mid-April through May.
- Nearly half (43.5%) of Medicare primary care visits were provided via telehealth in April, compared with less than one percent before the PHE in February (0.1%).
- As in-person visits started to resume from mid-April thru May, the use of telehealth in primary care declined somewhat but appears to have leveled off at a persistent and significant level by the beginning of June.
- Beneficiaries dually enrolled in Medicare and Medicaid, and high-cost Medicare beneficiaries had similar patterns in the use of primary care in-person and telehealth visits as other Medicare beneficiaries.
- Providers in rural counties had smaller increases in Medicare primary care telehealth visits compared with providers in urban areas who had much greater use of telehealth visits early in the PHE.
- Among major urban areas, the proportion of total primary care visits delivered by telehealth in April ranged from one third in Phoenix to nearly two-thirds in Boston. Cities with more COVID-19 hospitalizations like New York City, Detroit and Boston had higher uptake of telehealth in primary care visits along with San Francisco, which largely avoided the early COVID-19 surge. This suggests telehealth is partly driven by concerns with COVID-19, but also patient and provider readiness for telehealth.

### BACKGROUND

Use of telehealth to deliver health care services has sky rocketed during the COVID-19 Public Health Emergency (PHE). This paper provides early information on one aspect of that growth: use of telehealth for delivery of primary care services in Fee-for-Service (FFS) Medicare. About 38.5 million Medicare beneficiaries

receive their health coverage through FFS Medicare.<sup>1</sup> This paper seeks to address the issue of how and whether the Medicare telehealth flexibilities introduced to address the COVID-19 pandemic may have helped maintain access to primary health care during the PHE. This paper is a deeper dive into Medicare FFS primary care telehealth visits<sup>2</sup> - with more recent data on changes in telehealth use through the first week of June than numbers on telehealth released by the Centers for Medicare and Medicaid Services (CMS) in July in a Health Affairs blog.<sup>[16]</sup> It will describe the Medicare FFS telehealth statutory and regulatory landscape prior to the PHE; identify major telehealth flexibilities put into place for the duration of the PHE; describe telehealth primary care utilization during the PHE using real-time un-adjudicated Medicare claims data, by geography, dual eligibility status, and other key patient characteristics and compare this to previous usage. It will also identify key policy implications and propose areas for more study.

In defining telehealth, many organizations<sup>[1]</sup> use the Health Resources and Services Administration's (HRSA) Federal Office of Rural Health Policy's definition: telehealth is "the use of electronic information and telecommunication technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications."<sup>[2]</sup> In general, for this brief, we consider telehealth services generally as an interactive medical consultation between a patient and a health care provider which can happen synchronously or asynchronously by voice only, voice and video, chat or email.

**Medicare statute:** Under the Medicare statute, the telehealth services that could be covered and where services could be provided, both by geographic location and service delivery site in FFS Medicare has been more limited than HRSA's broad definition. Medicare telehealth services are codified at section 1834(m) of the Social Security Act. They were first authorized in FFS Medicare by the Balanced Budget Act of 1997, and were implemented in 2001.<sup>[3]</sup> The definition of "telehealth services" established an initial set of services to be covered, to be updated annually. Originally, telehealth services were restricted to beneficiaries being provided care in physician offices, hospitals, critical access hospitals, rural health clinics and Federally Qualified Health Centers located in Health Professional Shortage Areas (HPSA). These services required the presence of a clinician at both the originating site where the patient was and the distant site where the provider "expert" was located. Over the years, through several statutory changes, FFS Medicare telehealth was expanded to cover all counties outside a metropolitan statistical area, the requirement that a clinician be present at the originating site was removed, and additional originating sites were added, including community mental health centers, end stage renal disease facilities located in a hospital and skilled nursing facilities (SNFs).

In the last few years, Congress authorized some exceptions to the Section 1834(m) requirements that apply to telehealth in FFS Medicare for substance use disorder,<sup>[4]</sup> end-stage renal disease<sup>[5]</sup> (ESRD) and stroke through the SUPPORT Act and Bipartisan Budget Act of 2018, which also allowed additional telehealth benefits in Medicare Advantage.<sup>3</sup> Also, beginning in January 2019,<sup>[6]</sup> CMS has used its regulatory authority to provide for payment for "communication technology-based services." These include virtual check-ins—a brief, non-face-to-face check-in with an established patient via communication technology to assess whether or not an office visit or other service is necessary; remote patient monitoring of established patients; and teleconsults

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<sup>1</sup> CMS Fast Facts, February 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts>

<sup>2</sup> This brief focuses on FFS Medicare because data for the early period of COVID-19 is readily available for analysis. By contrast, data from Medicare Advantage plans, that also cover telehealth services, are not yet available for this analysis. This brief includes data up to June 3rd, available as of June 16. Providers have up to one year to file claims, so these findings are preliminary pending complete data files.

<sup>3</sup> CMS Finalizes Policies to Bring Innovative Telehealth Benefit to Medicare Advantage, CMS press release April 5, 2019, <https://www.cms.gov/newsroom/press-releases/cms-finalizes-policies-bring-innovative-telehealth-benefit-medicare-advantage>

between professionals conducted through communications technology. These services are not considered to fall within the Section 1834(m) definition of “Medicare telehealth” and therefore, the geographic and site of service restrictions do not apply.

**Response to COVID-19--Medicare telehealth flexibilities:** To respond to the urgent need to protect beneficiaries from COVID-19, Congress included telehealth provisions in the Coronavirus Aid, Relief, and Economic Security (CARES) Act.<sup>[7]</sup> Through the emergency declaration under the Stafford Act and the National Emergencies Act, CMS also used emergency rulemaking<sup>[8]</sup> to provide Medicare telehealth flexibilities<sup>[9]</sup> for the duration of the COVID-19 PHE. These addressed several aspects of the existing Medicare telehealth benefit<sup>4</sup> – expanding the list of telehealth-eligible services, providing technology flexibilities allowing audio-only communications, as well as expanding the types of practitioners eligible to provide telehealth services. From March 6, 2020, using 1135 waiver authority,<sup>5</sup> CMS also removed some of the geographic and site of service requirements to allow telehealth services to be delivered wherever a beneficiary is located, including their home or temporary health care sites. Previously, a beneficiary had to go to a health care facility to receive telehealth services from a distant site provider. However, Medicare telehealth service providers must still be located in the US. Finally, the HHS Office for Civil Rights is exercising its enforcement discretion and will not impose Health Insurance Portability and Accountability Act (HIPAA) penalties on covered health care providers for violations of the HIPAA Rules in connection with the good faith delivery of telehealth using non-public facing technologies.<sup>[10]</sup> These changes allowed health care providers to deliver more health care services through telehealth. The Medicare telehealth requirements and flexibilities are summarized in Appendix A.

**National trends in telehealth utilization changes related to COVID-19:** Since the start of the COVID-19 pandemic, there has been a surge in telehealth adoption and usage by health care providers, telehealth providers and health insurers. Several reports<sup>[11, 12, 13]</sup> using health care provider databases have also shown large decreases of about 60-70% in health care office visits across payers and specialties with the start of the pandemic, that have been partially offset by telehealth visits. IQVIA data showed telehealth adoption varied by specialty – telehealth increased for psychiatry (60% of interactions), gastroenterology (49%), neurology (41%), but was low for OB/GYN (12%) and hematology/oncology (8%). Results from an IQVIA survey of about 300 practitioners (primary care and specialists) between April 17 and 22, indicated that prior to the pandemic, about 9% of patient interactions for the surveyed practitioners was via telehealth, however, the telehealth interactions increased to 51% during the quarantine, and is expected to be 21% after the pandemic.<sup>[12]</sup>

## METHODS

To evaluate telehealth use during the COVID-19 public health emergency, we used Medicare FFS Part B claims from January into June 2020 for primary care services. Primary care services included evaluation and management (E&M), preventive services, and advance care planning (see Appendix B). Primary care E&M services also may include some mental health services. We used Medicare’s shared systems data, the most up-to-date source for claims submitted to Medicare, which includes all claims processed past the enumeration stage. This brief includes preliminary Medicare Part B primary care claims data through June 3<sup>rd</sup>, available as of June 16<sup>th</sup>; these numbers are preliminary estimates as providers have up to one year to file claims.

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<sup>4</sup> Physicians and Other Clinicians: CMS Flexibilities to Fight COVID-19, CMS document, April 29, 2020, <https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf>

<sup>5</sup> Medicare Telemedicine Health Care Provider Fact Sheet, CMS press release, March 17, 2020, <https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet>

Medicare telehealth services were identified by the appropriate Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code listed in the CMS telehealth eligible codes.<sup>6</sup> For primary care services that could be provided either in-person or by telehealth, telehealth services were identified when the modifier code 95 was present. We did not examine the use of communications technology-based services such as virtual check-ins. Not all Medicare telehealth visits to rural health clinics (RHCs) may have been captured since recent guidance<sup>7</sup> indicates the modifier “95” is optional for RHC and federally qualified health clinic (FQHC) specific codes, and the CMS list of telehealth eligible codes did not include the code G2025 which typically denotes telehealth visits in RHCs and FQHCs.<sup>8</sup>

We evaluated the number of primary care services provided, the proportion of primary care services provided via telehealth, and the rate of services per Medicare FFS enrollee. The number of primary care services is a rolling total of the number of primary care visits for each of the last 7 days to smooth out weekly trends in service use. The proportion of primary care services provided via telehealth is the total number of telehealth visits divided by the total number of primary care visits. The rate of services is the number of visits (in-person, telehealth, or either) divided by the number of enrolled FFS beneficiaries in January 2020 reported by CMS.<sup>9</sup>

We evaluated primary care visits for all FFS beneficiaries, dually enrolled beneficiaries, and beneficiaries with high predicted spending. Beneficiaries included were enrolled in Medicare Parts A and B at the time of the primary care visit; claims for beneficiaries enrolled in Medicare Advantage are not submitted to Medicare through the shared systems data. As noted above, Medicare Advantage encounter data will be available for analysis at a later date. Dually enrolled beneficiaries were enrolled in both Medicare and Medicaid at the time of the primary care visit and/or for the two calendar months prior. High predicted spending beneficiaries were those with a Hierarchical Condition Category (HCC) score in the top quartile based on 2019 claims, an indicator of greater disease burden and health service use.

Finally, we assess primary care service use by geography. In-person and telehealth services were assigned to the county of the distant site where the provider was located, no matter where the beneficiary was located or lived. However, for these geographic analyses, rates per Medicare enrollee still used the number of FFS enrollees in the county for the denominator. Counties that were in a Metropolitan or Micropolitan Core-Based Statistical Area (CBSA) as defined by the Office of Management and Budget (OMB) using Census data, were considered urban.<sup>10</sup> All other counties were considered rural.

We compared primary care visits to rates of COVID-19 hospitalizations among Medicare beneficiaries, identifying COVID-19 hospitalizations using the U071 ICD-10 CM code. We further examined several CBSAs with high rates of COVID-19 during the time period represented by these data: New York-Northern New Jersey-Long Island (New York), Boston-Cambridge-Quincy (Boston), Seattle-Tacoma-Bellevue (Seattle), and Phoenix-Mesa-Scottsdale (Phoenix). We compare these four CBSAs to national trends to determine if telehealth use differed in areas with high rates of COVID-19 in the early days of the pandemic.

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<sup>6</sup> CMS List of Telehealth Service Codes, last modified April 30, 2020, <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

<sup>7</sup> New and Expanded Flexibilities for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) During the COVID-19 Public Health Emergency (PHE), MLN Matters, July 6, 2020, <https://www.cms.gov/files/document/se20016.pdf>

<sup>8</sup> Codes used in this analysis differ from the way CMS identified telehealth utilization in the recent CMS blog in Health Affairs, and may not have captured all telehealth visits in RHCs and FQHCs.

<sup>9</sup> Medicare Enrollment Dashboard, January 2020, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>

<sup>10</sup> U.S. Census, Core-Based Statistical Areas, <https://www.census.gov/topics/housing/housing-patterns/about/core-based-statistical-areas.html>

## FINDINGS

Nearly half of all Medicare primary care visits were via telehealth in April, compared with less than 1% in February before the start of the COVID-19 pandemic.

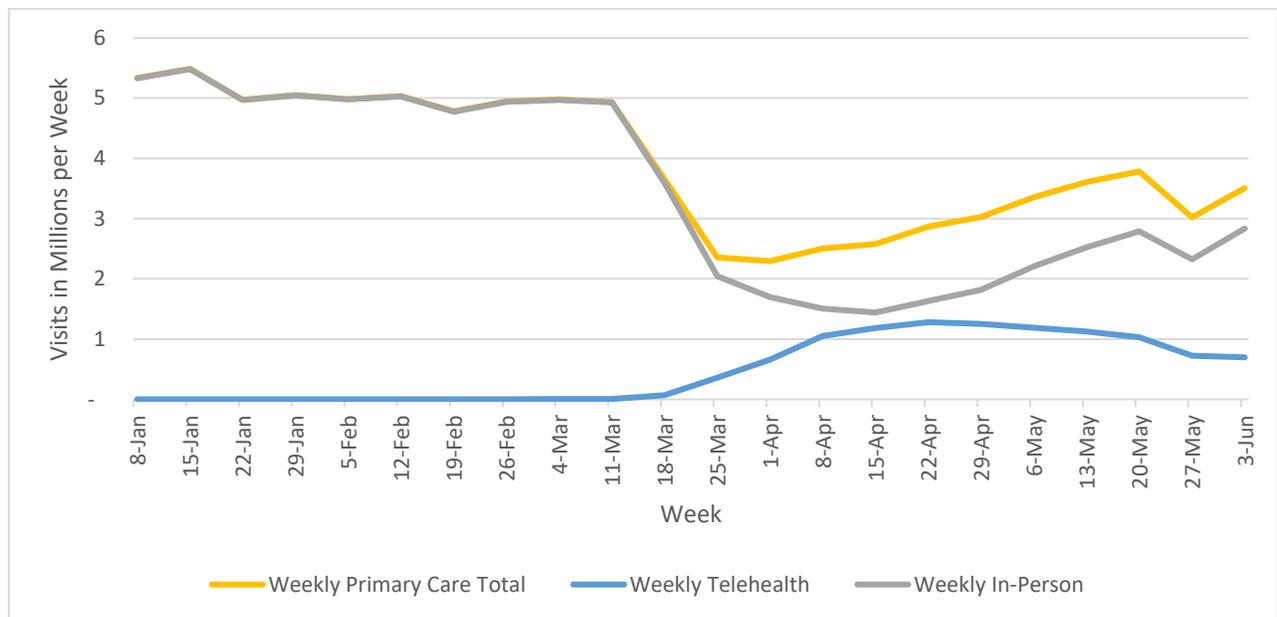
Total and in-person primary care visits fell precipitously among Medicare beneficiaries in mid-March, and then began to rise again in late March through May (Figure 1), although the weekly primary care visit rate has not yet returned to pre-PHE levels. Values for the figures can be found in Appendix C.

At the beginning of the year, there were a limited number of Medicare primary care telehealth visits in part due to Medicare restrictions on telehealth before the PHE.

At the same time that total primary care visits were dropping, the number of telehealth visits began climbing, with nearly half of all primary care visits provided via telehealth in April, or 1.28 million telehealth visits per week. In May, the number of telehealth visits began to drop as in-person visits resumed, with only 30% of primary care visits in that month provided by telehealth, about 700,000 visits per week.

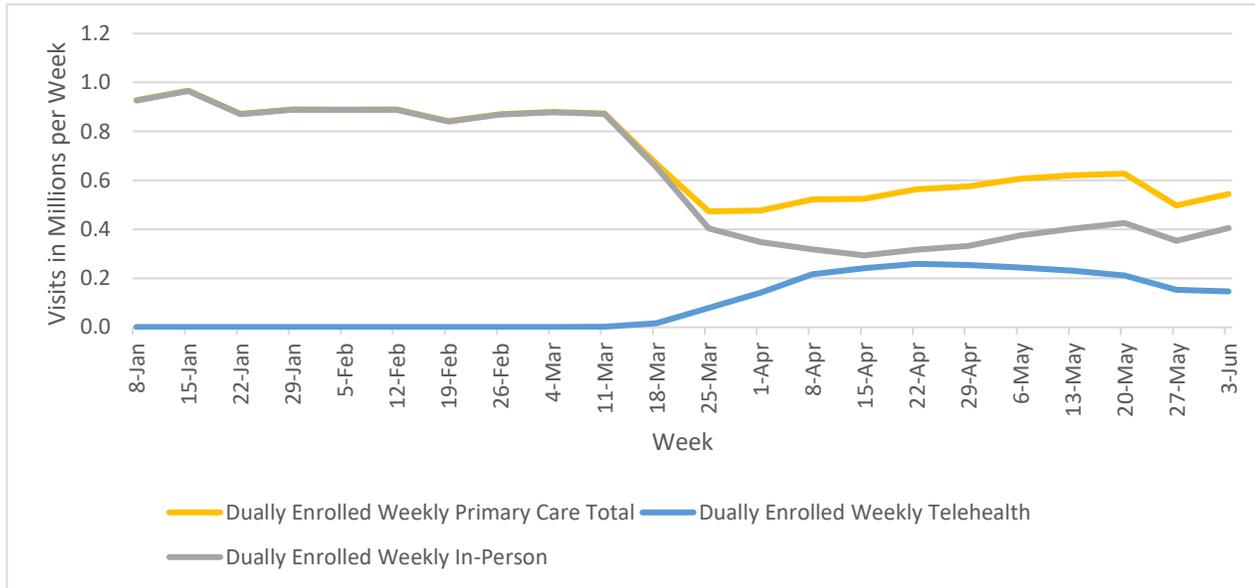
This represents a 350-fold increase from pre-pandemic levels of about 2,000 primary care telehealth visits per week in February. Overall trends were similar for dually enrolled beneficiaries (Figure 2) and high cost beneficiaries (Figure 3).

Figure 1. Primary Care Visits for FFS Medicare Beneficiaries (visits in millions per week)



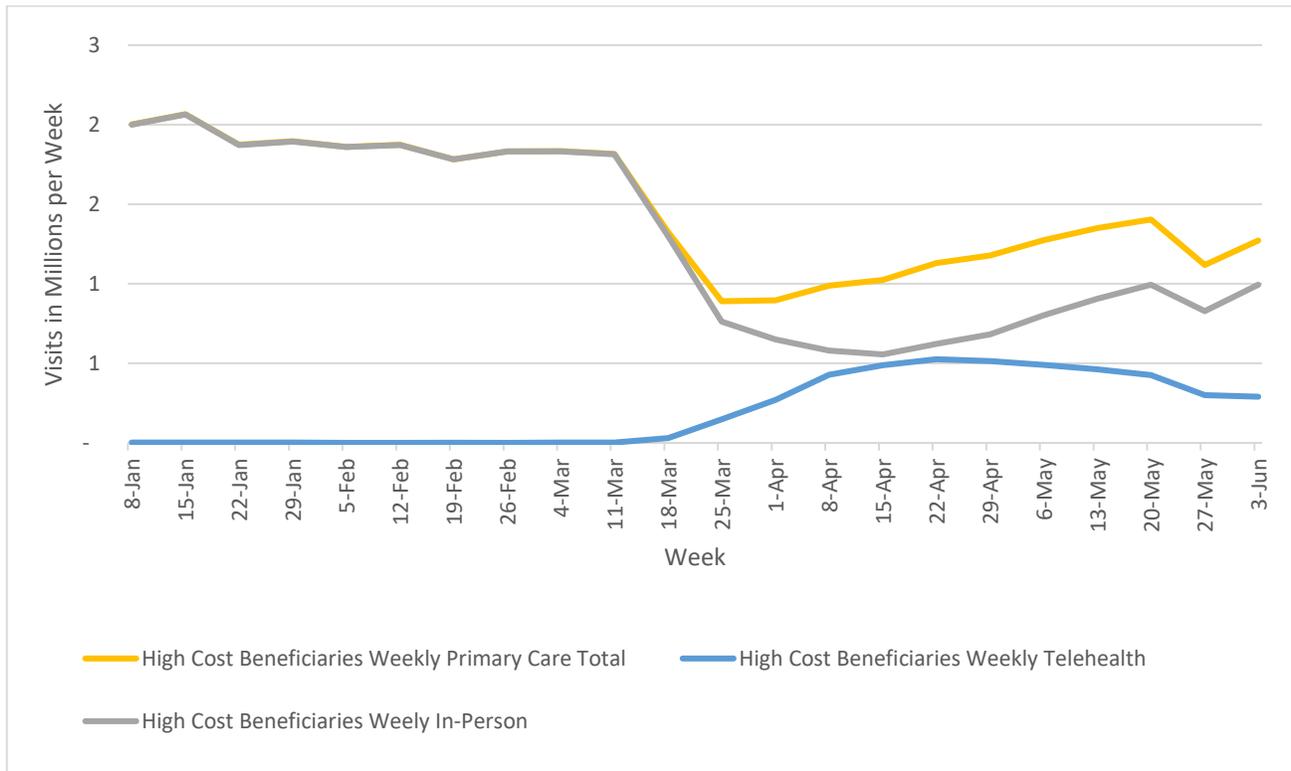
Source: Medicare claims data up to June 3rd, available as of June 16.

Figure 2. Primary Care Visits for Beneficiaries Dually Enrolled in FFS Medicare and Medicaid (visits in millions per week)



Source: Medicare claims data up to June 3<sup>rd</sup>, available as of June 16.

Figure 3. Primary Care Visits for High Cost FFS Medicare Beneficiaries (visits in millions per week)

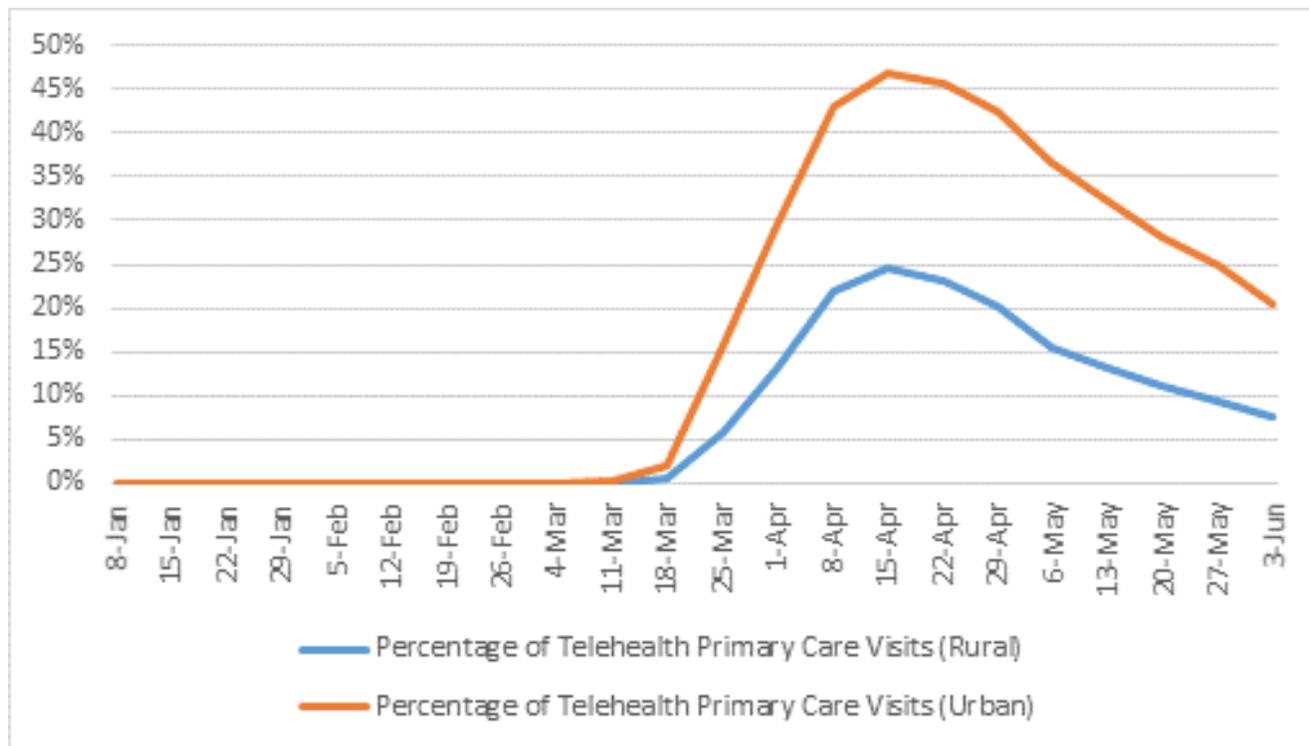


Source: Medicare claims data up to June 3<sup>rd</sup>, available as of June 16.

Although providers in urban and rural counties followed the same primary care trends, total visits and patterns of telehealth use differed (see Appendix C, Table 5). Providers in rural counties saw a small growth in telehealth visits as a proportion of all primary care visits in March and April that fell again in May (Figure 4).

Providers in urban counties, on the other hand, saw much greater telehealth use early in the PHE and smaller declines in May. The figure may under-represent the use of telehealth by rural patients who may have a telehealth visit with an urban provider, since the geographic location here is based on the location of the distant site provider delivering the telehealth consultation, not the beneficiary’s location.

**Figure 4. Telehealth Weekly Visits as a Percentage of Total FFS Medicare Primary Care Visits in Urban and Rural Counties**



Source: Medicare claims data up to June 3<sup>rd</sup>, available as of June 16.

Among the 15 most populous urban areas, the proportion of total primary care visits delivered by telehealth in April ranged from 37% in Phoenix to nearly three quarters in Boston (Table 1). Telehealth adoption was widespread among these urban areas, but was not strongly associated with differences in COVID-19 severity across cities as measured by rate of hospitalizations per thousand Medicare FFS beneficiaries.

Table 1. Proportion of FFS Medicare Primary Care Visits via Telehealth and Medicare COVID-19 Hospitalization Rate, by Core-Based Statistical Area (CBSA)

	February		April		
	Total Primary Care Visits	Percent Telehealth	Total Primary Care Visits	Percent Telehealth	Medicare COVID-19 Hospitalizations per Thousand Beneficiaries
<b>US TOTAL</b>	<b>19,655,604</b>	<b>0.1%</b>	<b>4,786,049</b>	<b>43.5%</b>	<b>11.7</b>
Boston, MA	355,687	0.0%	237,694	73.1%	35.7
Minneapolis-St. Paul, MN	123,001	0.1%	71,806	63.9%	4.9
Philadelphia, PA	416,398	0.0%	229,355	61.6%	24.0
San Francisco, CA	187,845	0.2%	105,112	60.2%	3.7
Detroit, MI	225,850	0.1%	126,331	59.7%	60.3
New York, NY	1,233,990	0.1%	634,558	56.5%	59.5
Chicago, IL	512,752	0.0%	289,301	52.4%	24.5
Dallas, TX	320,465	0.0%	188,693	52.2%	4.8
Washington, DC	372,015	0.1%	209,979	50.7%	12.8
Seattle, WA	159,261	0.1%	84,928	48.2%	7.5
Los Angeles, CA	529,503	0.1%	300,283	46.3%	16.3
Houston, TX	257,008	0.0%	144,313	46.2%	7.1
Miami, FL	366,302	0.0%	198,779	43.9%	21.3
Atlanta, GA	260,596	0.0%	138,613	42.1%	10.5
Phoenix, AZ	315,174	0.0%	185,470	37.8%	4.2

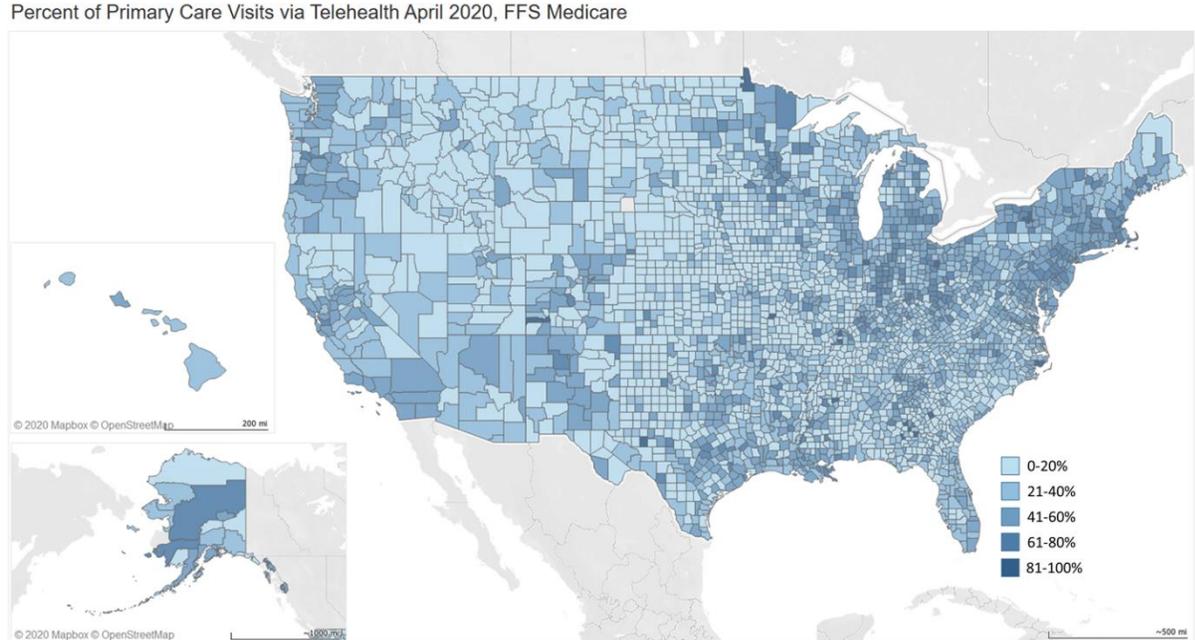
Note: Hospitalizations rates calculated using Medicare claims among IPPS/CAH hospitals. Rates reported as 0% may include some hospitalizations but are below 0.1%.

The range of telehealth adoption across counties is also shown in a map of the US in Figure 5 with generally high adoption of telehealth across the country. Overall, while only 0.04% of the total US population have no access to Internet providers, broadband is generally more widely available in urban areas. Comparing broadband availability, a tool by the Federal Communications Commission<sup>11</sup> shows in areas with 3 or more Internet providers, on average 78.9% of the population had broadband access in rural areas compared to

<sup>11</sup> Federal Communications Commission, Fixed Broadband Deployment, Area Comparison, as of June 2019, [https://broadbandmap.fcc.gov/#/area-comparison?version=jun2019&tech=acfosw&speed=25\\_3&searchtype=county](https://broadbandmap.fcc.gov/#/area-comparison?version=jun2019&tech=acfosw&speed=25_3&searchtype=county)

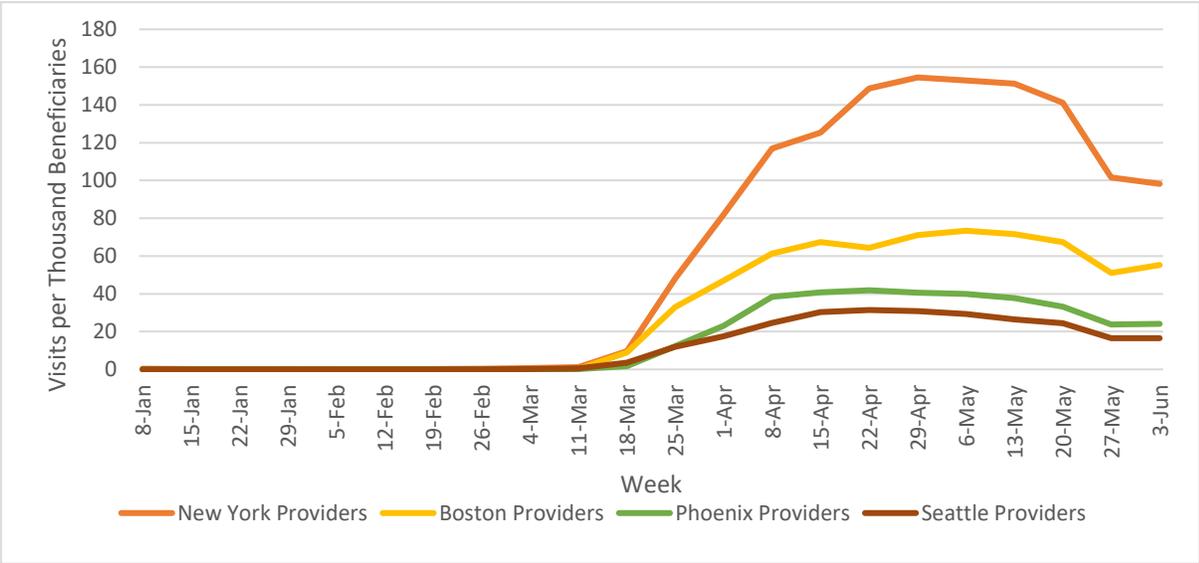
99.8% of the population in urban areas. However this varies widely by area, with the lowest availability covering just 36% and 15% of the urban and rural population.

Figure 5. US Counties: Medicare FFS - Percent of Primary Care Visits via Telehealth, April 2020



Source: Medicare claims data for primary care visits via telehealth, April 2020

Figure 6. Telehealth Primary Care Visits per Thousand FFS Medicare Beneficiaries for Providers in New York City, Boston, Phoenix, and Seattle



Source: Medicare claims data up to June 3<sup>rd</sup>, available as of June 16.

The trends during the PHE for the four urban areas in Figure 6. Telehealth Primary Care Visits per Thousand FFS Medicare Beneficiaries for Providers in New York City, Boston, Phoenix, and Seattle all show an uptake of

telehealth primary care at the beginning of the PHE, but to varying degrees, with the highest uptake in New York City, followed by Boston, Phoenix and Seattle.

## SUMMARY

Based on early experience with Medicare primary care telehealth at the start of the COVID-19 public health emergency, there is evidence that Medicare's new telehealth flexibilities played a critical role in helping to maintain access to primary health care services - when many beneficiaries and providers were concerned with transmission of COVID-19. The stable and sustained use of telehealth after in-person primary care visits started to resume in mid-April suggests there may be continued demand for telehealth in Medicare, even after the pandemic ends. The Medicare telehealth and in-person visit trends are supported by outpatient provider trends across payers in recent analyses published by the Commonwealth Fund,<sup>[14]</sup> showing telehealth helps maintain but does not completely substitute for outpatient in-person visits. Telehealth adoption was widespread and does not appear to be correlated with COVID-19 hospitalizations in major urban areas, but may reflect provider readiness to implement telehealth. For example, tech-savvy cities like San Francisco also show high telehealth usage despite lower per Medicare beneficiary hospitalization rates of COVID-19.

## FUTURE RESEARCH

There is broad interest and discussion regarding whether some or all of the Medicare telehealth flexibilities should be made permanent after the pandemic ends. For example, Senate Health Education, Labor and Pensions Committee chair Lamar Alexander (R-Tenn.) supports<sup>[15]</sup> making permanent two of the COVID-19 telehealth flexibilities – allowing telehealth wherever the beneficiary is located, including the beneficiary's home, and expanding the scope of telehealth reimbursable services. To inform these potential policy changes, evaluation of the impact of the Medicare telehealth flexibilities during the PHE across the country and for different groups of beneficiaries could be helpful. This could include a closer examination of Medicare telehealth use by provider type, by beneficiary characteristics including race/ethnicity to assess potential disparities, geography, types of services and settings during the PHE. Evaluation of the impact of OCR's exercise of enforcement discretion under the HIPAA Rules in connection with the good faith delivery of telehealth allowing the use of multiple tele-video platforms would also help inform whether the increased availability of platforms facilitated use of telehealth during the pandemic.

These findings are consistent with CMS reported telehealth utilization. CMS' blog in Health Affairs in July<sup>[16]</sup> reporting data on overall telehealth utilization in the first month of the pandemic shows similar rates of telehealth use by race/ethnicity, but slightly lower use of telehealth by beneficiaries living in rural areas than those in urban areas, and regional variation in telehealth adoption. CMS also found that mental health services were commonly provided using telehealth, and one-third of telehealth visits relied on the traditional telephone. Further analysis of specific telehealth services by rural location and patient characteristics and health conditions could inform how to expand or maintain telehealth access for at-risk beneficiaries, especially those with limited access to broadband or audio-visual technologies. The urban/rural difference in telehealth is likely affected by lower availability of broadband in rural areas. Further research is needed on why telehealth usage may be lower among rural providers, if recent guidance for RHCs and FQHCs on the optional use of the "95" modifier may have limited our ability to identify all telehealth visits, and whether use of telephone-only telehealth visits may have mitigated some of the challenges rural providers and beneficiaries face.

A key question for future research will be to assess if the Medicare telehealth flexibilities were effective, such as mitigating potential adverse health and cost impacts from COVID-19, including foregone health care. Future research could also examine whether telehealth may have improved access to care and health outcomes among underserved beneficiaries.

## APPENDIX A: The Medicare Telehealth Benefit

Table 1. Summary of changes in Medicare telehealth benefit with the flexibilities for the COVID-19 public health emergency

	Distant Site Telehealth Practitioner Types Allowed	Geographic Location and Telehealth Originating Site	Telehealth Technology Requirements
<b>Medicare telehealth restrictions (before COVID-19)</b>	<ul style="list-style-type: none"> <li>• Doctors</li> <li>• Nurse practitioners</li> <li>• Physician assistants</li> <li>• Nurse-midwives</li> <li>• Clinical psychologists and clinical social workers</li> <li>• Nurse specialists</li> </ul>	Rural, health professional shortage areas Authorized originating sites: <ul style="list-style-type: none"> <li>• Physician and practitioner offices</li> <li>• Hospitals</li> <li>• Critical Access Hospitals (CAHs)</li> <li>• Rural Health Clinics</li> <li>• Federally Qualified Health Centers</li> <li>• Hospital-based or CAH-based Renal Dialysis Centers (including satellites)</li> <li>• Skilled Nursing Facilities (SNFs)</li> <li>• Community Mental Health Centers (CMHCs)</li> <li>• Renal Dialysis Facilities</li> <li>• Homes of beneficiaries with End-Stage Renal Disease (ESRD) getting home dialysis</li> <li>• Mobile Stroke Units</li> </ul>	<ul style="list-style-type: none"> <li>• Interactive two-way, audio/video telecommunications technology</li> <li>• Use of technology must meet HIPAA privacy and security requirements</li> </ul>
<b>Temporary telehealth flexibilities during COVID-19 public health emergency</b>	<ul style="list-style-type: none"> <li>• Removes all restrictions on practitioner type</li> </ul>	<ul style="list-style-type: none"> <li>• Removal of rural restrictions – expands telehealth to urban areas</li> <li>• Originating sites also includes temporary hospitals</li> <li>• Beneficiary’s home</li> </ul>	<ul style="list-style-type: none"> <li>• Interactive</li> <li>• Audio-only for certain services</li> <li>• Enforcement discretion allows use of non-public facing remote communications products that are not HIPAA-compliant</li> </ul>
<b>Medicare Reimbursement</b>	Practitioners paid same for telehealth visit as in-person visit during PHE (based on the non-facility rate. Normally telehealth visits are reimbursed at the facility rate).	Originating site fees allowed for temporary locations	

## APPENDIX B: Primary Care Claims Codes

The table below lists the Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes used in this study to identify Medicare primary care visits. The codes indicate if the Medicare visit is allowed only as an in-person visit or telehealth visit, or if either is allowed. For codes where either is allowed, claims with CPT or HCPCS modifier code 95 are classified as telehealth visits and those without the modifier code 95 are classified as in-person visits.

Table 1. Primary Care Claims Codes

Code	Code Type	Description	Telehealth/ In-Person
99441	CPT	Physician telephone patient service, 5-10 minutes of medical discussion	Telehealth only
99442	CPT	Physician telephone patient service, 11-20 minutes of medical discussion	Telehealth only
99443	CPT	Physician telephone patient service, 21-30 minutes of medical discussion	Telehealth only
99444	CPT	Physician or health care professional evaluation and management of patient care by internet (email) related to visit within previous 7 days	Telehealth only
99421	CPT	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 5-10 minutes	Telehealth only
99422	CPT	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 11-20 minutes	Telehealth only
99423	CPT	Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7 days; 21 or more minutes	Telehealth only
98966	CPT	Telephone assessment and management service, 5-10 minutes of medical discussion	Telehealth only
98967	CPT	Telephone assessment and management service, 11-20 minutes of medical discussion	Telehealth only
98968	CPT	Telephone assessment and management service, 21-30 minutes of medical discussion	Telehealth only
99201	CPT	New patient office or other outpatient visit, typically 10 minutes	In-person or telehealth
99202	CPT	New patient office or other outpatient visit, typically 20 minutes	In-person or telehealth

Code	Code Type	Description	Telehealth/ In-Person
99203	CPT	New patient office or other outpatient visit, typically 30 minutes	In-person or telehealth
99204	CPT	New patient office or other outpatient visit, typically 45 minutes	In-person or telehealth
99205	CPT	New patient office or other outpatient visit, typically 60 minutes	In-person or telehealth
99211	CPT	Established patient office or other outpatient visit, typically 5 minutes	In-person or telehealth
99212	CPT	Established patient office or other outpatient visit, typically 10 minutes	In-person or telehealth
99213	CPT	Established patient office or other outpatient visit, typically 15 minutes	In-person or telehealth
99214	CPT	Established patient office or other outpatient, visit typically 25 minutes	In-person or telehealth
99215	CPT	Established patient office or other outpatient, visit typically 40 minutes	In-person or telehealth
G0466	HCPCS	Federally qualified health center (FQHC) visit, new patient; a medically-necessary, face-to-face encounter (one-on-one) between a new patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit	In-person or telehealth
G0467	HCPCS	FQHC visit, established patient; a medically-necessary, face-to-face encounter (one-on-one) between an established patient and a FQHC practitioner during which time one or more FQHC services are rendered and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving a FQHC visit	In-person or telehealth
G0506	HCPCS	Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)	In-person or telehealth
G0511	HCPCS	Rural health clinic (RHC) or FQHC only, general care management, 20 minutes or more of clinical staff time for chronic care management services or behavioral health integration services directed by an RHC or FQHC practitioner (physician, nurse practitioner (NP), physician assistant (PA), or certified nurse midwife (CNM)), per calendar month	In-person or telehealth

Code	Code Type	Description	Telehealth/ In-Person
G0512	HCPCS	RHC/FQHC only, psychiatric collaborative care model (psychiatric cocm), 60 minutes or more of clinical staff time for psychiatric cocm services directed by an RHC or FQHC practitioner (physician, NP, PA, or CNM) and including services furnished by a behavioral health care manager and consultation with a psychiatric consultant, per calendar month	In-person or telehealth
G0402	HCPCS	Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment	In-person only
G0438	HCPCS	Annual wellness visit; includes a personalized prevention plan of service (PPS), initial visit	In-person only
G0439	HCPCS	Annual wellness visit, includes a PPS, subsequent visit	In-person only
G0468	HCPCS	FQHC visit that includes an initial preventive physical examination (IPPE) or annual wellness visit (AWV) and includes a typical bundle of Medicare-covered services that would be furnished per diem to a patient receiving an IPPE or AWV	In-person only
G0513	HCPCS	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service)	In-person only
G0514	HCPCS	Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; each additional 30 minutes (list separately in addition to code G0514 for additional 30 minutes of preventive service)	In-person only
99497	CPT	Advance care planning by the physician or other qualified health care professional, first 30 minutes	In-person only
99498	CPT	Advance care planning by the physician or other qualified health care professional, additional 30 minutes	In-person only
99401	CPT	Preventive medicine counseling, approximately 15 minutes	In-person only
99402	CPT	Preventive medicine counseling, approximately 30 minutes	In-person only
99403	CPT	Preventive medicine counseling, approximately 45 minutes	In-person only
99404	CPT	Preventive medicine counseling, approximately 60 minutes	In-person only
99406	CPT	Smoking and tobacco use intermediate counseling, greater than 3 minutes up to 10 minutes	In-person only

Code	Code Type	Description	Telehealth/ In-Person
99407	CPT	Smoking and tobacco use intensive counseling, greater than 10 minutes	In-person only
99408	CPT	Alcohol and/or substance abuse screening and intervention, 15-30 minutes	In-person only
99409	CPT	Alcohol and/or substance abuse screening and intervention, greater than 30 minutes	In-person only
99411	CPT	Group preventive medicine counseling, approximately 30 minutes	In-person only
99412	CPT	Group preventive medicine counseling, approximately 60 minutes	In-person only

## APPENDIX C: Figure Values

Table 2. Primary Care Visits for FFS Medicare Beneficiaries

Week Ending	Primary Care Visits	In-Person Visits	Telehealth Visits	
			Visits	% of Total Primary Care Visits
8-Jan	5,333,311	5,331,259	2,538	0.1%
15-Jan	5,485,013	5,481,882	3,800	0.1%
22-Jan	4,970,680	4,968,613	2,533	0.1%
29-Jan	5,048,665	5,046,580	2,500	0.0%
5-Feb	4,979,999	4,978,043	2,384	0.0%
12-Feb	5,032,617	5,030,710	2,326	0.0%
19-Feb	4,778,275	4,776,511	2,122	0.0%
26-Feb	4,941,729	4,939,770	2,330	0.0%
4-Mar	4,975,578	4,972,384	4,109	0.1%
11-Mar	4,933,228	4,927,803	6,673	0.1%
18-Mar	3,653,232	3,591,969	70,050	1.9%
25-Mar	2,355,186	2,043,829	359,025	15.2%
1-Apr	2,295,159	1,698,620	661,389	28.8%
8-Apr	2,504,958	1,506,504	1,051,587	42.0%
15-Apr	2,580,353	1,441,858	1,183,961	45.9%
22-Apr	2,868,304	1,633,909	1,280,210	44.6%
29-Apr	3,024,487	1,817,405	1,251,391	41.4%
6-May	3,353,857	2,208,546	1,190,725	35.5%
13-May	3,605,741	2,525,549	1,124,171	31.2%
20-May	3,781,822	2,791,536	1,031,926	27.3%
27-May	3,019,424	2,324,351	724,917	24.0%
3-Jun	3,509,689	2,838,900	698,812	19.9%

Note: Percentages reported as 0.0% reflect values between 0.0% and 0.05%.

Table 3. Primary Care Visits for FFS Medicare Beneficiaries Dually Enrolled in Medicare and Medicaid

Week Ending	Primary Care Visits	In-Person Visits	Telehealth Visits	
			Visits	% of Total Primary Care Visits
8-Jan	928,104	926,977	1,350	0.1%
15-Jan	966,538	965,299	1,456	0.2%
22-Jan	871,310	870,181	1,338	0.2%
29-Jan	889,716	888,537	1,337	0.2%
5-Feb	889,298	888,295	1,185	0.1%
12-Feb	890,127	889,181	1,120	0.1%
19-Feb	841,493	840,630	1,002	0.1%
26-Feb	870,334	869,488	985	0.1%
4-Mar	879,820	878,730	1,368	0.2%
11-Mar	873,627	872,028	1,962	0.2%
18-Mar	668,307	653,741	16,709	2.5%
25-Mar	473,727	404,139	79,540	16.8%
1-Apr	476,661	348,511	141,896	29.8%
8-Apr	522,695	318,406	217,041	41.5%
15-Apr	524,309	293,747	242,050	46.2%
22-Apr	563,388	316,226	259,153	46.0%
29-Apr	575,455	332,981	253,968	44.1%
6-May	606,379	374,928	243,940	40.2%
13-May	621,000	402,363	230,575	37.1%
20-May	627,086	426,623	211,450	33.7%
27-May	498,118	352,762	153,588	30.8%
3-Jun	543,835	404,640	146,622	27.0%

Note: Percentages reported as 0.0% reflect values between 0.0% and 0.05%.

Table 4. Primary Care Visits for High Cost FFS Medicare Beneficiaries

Week Ending	Primary Care Visits	In-Person Visits	Telehealth Visits	
			Visits	% of Total Primary Care Visits
8-Jan	2,001,148	2,000,084	1,272	0.0%
15-Jan	2,065,799	2,064,273	1,818	0.1%
22-Jan	1,873,283	1,872,218	1,280	0.1%
29-Jan	1,895,677	1,894,610	1,246	0.1%
5-Feb	1,860,184	1,859,209	1,158	0.1%
12-Feb	1,873,780	1,872,867	1,081	0.1%
19-Feb	1,782,870	1,782,000	1,030	0.1%
26-Feb	1,832,101	1,831,214	1,065	0.1%
4-Mar	1,834,091	1,832,634	1,831	0.1%
11-Mar	1,816,484	1,814,141	2,854	0.2%
18-Mar	1,325,012	1,298,865	29,691	2.2%
25-Mar	890,188	761,722	147,692	16.6%
1-Apr	895,450	650,251	271,151	30.3%
8-Apr	987,235	580,528	428,290	43.4%
15-Apr	1,024,638	556,008	487,258	47.6%
22-Apr	1,129,360	622,381	525,739	46.6%
29-Apr	1,178,622	681,832	514,754	43.7%
6-May	1,273,544	802,408	489,288	38.4%
13-May	1,350,716	905,491	462,946	34.3%
20-May	1,403,321	993,885	426,325	30.4%
27-May	1,117,475	828,880	300,719	26.9%
3-Jun	1,272,202	994,218	289,372	22.7%

Note: Percentages reported as 0.0% reflect values between 0.0% and 0.05%.

Table 5. Telehealth Primary Care Visits per Thousand FFS Medicare Beneficiaries for Providers in Urban and Rural Counties

Week Ending	Telehealth Visits per 1,000 Medicare FFS Beneficiaries	
	Providers in Urban Counties	Providers in Rural Counties
8-Jan	0	0
15-Jan	0	0
22-Jan	0	0
29-Jan	0	0
5-Feb	0	0
12-Feb	0	0
19-Feb	0	0
26-Feb	0	0
4-Mar	0	0
11-Mar	0	0
18-Mar	2	0
25-Mar	10	2
1-Apr	19	5
8-Apr	30	8
15-Apr	34	9
22-Apr	37	10
29-Apr	36	9
6-May	35	8
13-May	33	7
20-May	30	6
27-May	21	4
3-Jun	21	4

Table 6. Telehealth Primary Care Visits per Thousand FFS Medicare Beneficiaries for Providers in New York City, Boston, Phoenix, and Seattle

Week Ending	New York	Boston	Phoenix	Seattle
8-Jan	0.3	0.1	0.0	0.1
15-Jan	0.3	0.0	0.0	0.1
22-Jan	0.3	0.0	0.0	0.0
29-Jan	0.2	0.0	0.0	0.0
5-Feb	0.2	0.0	0.0	0.1
12-Feb	0.2	0.0	0.0	0.1
19-Feb	0.2	0.1	0.0	0.1
26-Feb	0.3	0.1	0.0	0.1
4-Mar	0.7	0.2	0.1	0.2
11-Mar	1.2	0.3	0.2	0.5
18-Mar	9.7	8.9	1.8	3.6
25-Mar	48.2	33.0	12.3	12.0
1-Apr	82.1	46.9	23.0	17.6
8-Apr	116.9	61.4	38.5	24.6
15-Apr	125.3	67.4	40.8	30.3
22-Apr	148.7	64.3	41.9	31.4
29-Apr	154.5	71.2	40.5	30.8
6-May	152.9	73.4	39.9	29.4
13-May	151.2	71.7	37.7	26.5
20-May	141.2	67.4	33.2	24.5
27-May	101.5	51.0	23.7	16.6
3-Jun	98.1	55.2	24.2	16.4

Note: Values reported as 0.0 reflect values between 0.0 and 0.05.

Table 8. Proportion of Primary Care Visits via Telehealth in April, by State

	February		April	
	Total Primary Care Visits	Percent Telehealth	Total Primary Care Visits	Percent Telehealth
Massachusetts	525,988	0.0%	346,745	69.7%
Rhode Island	56,426	0.0%	39,280	61.7%
Connecticut	212,365	0.0%	113,838	58.7%
New York	1,123,915	0.1%	624,690	56.6%
Pennsylvania	750,124	0.0%	401,679	56.1%
New Jersey	628,187	0.0%	333,950	56.0%
Minnesota	230,110	0.1%	125,352	54.3%
New Hampshire	106,401	0.0%	58,096	53.8%
Michigan	494,532	0.2%	258,425	53.7%
Delaware	105,913	0.0%	58,823	53.6%
Maryland	521,870	0.0%	289,054	53.0%
Vermont	52,613	0.0%	30,009	50.7%
Indiana	423,814	0.1%	218,404	50.2%
Maine	84,716	0.0%	45,091	48.6%
Ohio	628,788	0.0%	328,946	48.6%
Wisconsin	272,855	0.0%	119,843	47.7%
Kentucky	325,865	0.0%	166,748	47.5%
Illinois	726,341	0.0%	389,838	46.9%
Oregon	210,183	0.1%	122,895	46.4%
Alaska	38,552	0.0%	23,833	46.0%
Louisiana	282,499	0.0%	144,561	45.6%
California	1,755,156	0.1%	1,014,717	44.9%
Colorado	229,559	0.1%	132,484	43.9%
Texas	1,315,670	0.2%	784,745	43.9%
New Mexico	118,419	0.0%	64,740	43.5%
Virginia	613,246	0.0%	342,187	43.2%

	February		April	
	Total Primary Care Visits	Percent Telehealth	Total Primary Care Visits	Percent Telehealth
District of Columbia	41,526	0.1%	21,625	42.4%
West Virginia	137,542	0.0%	71,636	41.4%
Washington	398,445	0.0%	215,019	41.1%
Hawaii	62,227	0.1%	32,808	38.3%
Puerto Rico	27,083	0.0%	9,129	37.3%
Mississippi	275,567	0.0%	158,368	35.6%
Missouri	363,346	0.0%	199,133	35.4%
Florida	1,761,226	0.0%	997,849	35.3%
North Carolina	707,791	0.0%	393,398	35.2%
Oklahoma	295,516	0.0%	174,274	34.7%
Arizona	507,899	0.0%	300,682	34.4%
Georgia	582,046	0.0%	321,745	34.3%
Iowa	220,314	0.0%	112,396	33.5%
South Dakota	60,394	0.0%	29,725	32.8%
Alabama	315,839	0.0%	191,518	31.9%
North Dakota	49,297	0.0%	28,949	31.2%
Nevada	166,792	0.0%	103,950	30.2%
Utah	115,145	0.0%	74,855	30.1%
South Carolina	431,042	0.0%	244,827	28.4%
Arkansas	249,767	0.0%	149,090	28.2%
Kansas	221,932	0.0%	121,346	28.0%
Wyoming	41,463	0.0%	24,154	27.3%
Montana	79,424	0.0%	43,742	27.0%
Tennessee	466,220	0.0%	272,578	25.8%
Idaho	99,919	0.0%	55,752	22.8%
Nebraska	143,735	0.0%	74,109	22.4%

Note: Percentages reported as 0.0% reflect values between 0.0% and 0.05%.

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