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MEDICARE AND MEDICAID

COVID-19 Program Flexibilities and Considerations for Their Continuation

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Accessible Version

GAO Highlights

Highlights of [GAO-21-575T](#), a testimony before the Committee on Finance, U.S. Senate

Why GAO Did This Study

Medicare and Medicaid—two federally financed health insurance programs—spent over \$1.5 trillion on health care services provided to about 140 million beneficiaries in 2020. Recognizing the critical role of these programs in providing health care services to millions of Americans, the federal government has provided for increased funding and program flexibilities, including waivers of certain federal requirements, in response to the COVID-19 pandemic.

The CARES Act includes a provision for GAO to conduct monitoring and oversight of the federal government's response to the COVID-19 pandemic. In response, GAO has issued a series of government-wide reports from June 2020 through March 2021. GAO is continuing to monitor and report on these services.

This testimony summarizes GAO's findings from these reports related to Medicare and Medicaid flexibilities during the COVID-19 pandemic, as well as preliminary observations from ongoing work related to telehealth waivers in both programs. Specifically, the statement focuses on what is known about the effects of these waivers and flexibilities on Medicare and Medicaid, and considerations regarding their ongoing use.

To conduct this work, GAO reviewed federal laws, CMS documents and guidance, and interviewed federal and state officials. GAO also interviewed six provider and beneficiary groups, selected based on their experience with telehealth services.

GAO obtained technical comments from CMS and incorporated them as appropriate.

View [GAO-21-575T](#). For more information, contact Jessica Farb at (202) 512-7114 or farbj@gao.gov or Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

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What GAO Found

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for overseeing Medicare and Medicaid, made widespread use of program waivers and other flexibilities to expand beneficiary access to care. Some preliminary information is available on the effects of these waivers. Specifically:

Medicare. CMS issued over 200 waivers and cited some of their benefits in a January 2021 report. For example, CMS reported that:

- **Expansion of hospital capacity.** More than 100 new facilities were added through the waivers that permitted hospitals to provide care in non-hospital settings, including beneficiaries' homes.
- **Workforce expansion.** Waivers and other flexibilities that relaxed certain provider enrollment requirements and allowed certain nonphysicians, such as nurse practitioners, to provide additional services expanded the provider workforce.
- **Telehealth waivers.** Utilization of telehealth services—certain services that are normally provided in-person but can also be provided using audio and audio-video technology—increased sharply. For example, utilization increased from a weekly average of about 325,000 services in mid-March to peak at about 1.9 million in mid-April 2020.

Medicaid. CMS approved more than 600 waivers or other flexibilities aimed at addressing obstacles to beneficiary care, provider availability, and program enrollment. GAO has reported certain flexibilities such as telehealth as critical in reducing obstacles to care. Examples of other flexibilities included:

- Forty-three states suspended fee-for-service prior authorizations, which help ensure compliance with coverage and payment rules before beneficiaries can obtain certain services.
- Fifty states and the District of Columbia waived certain provider screening and enrollment requirements, such as criminal background checks.

While likely benefitting beneficiaries and providers, these program flexibilities also increase certain risks to the Medicare and Medicaid programs and raise considerations for their continuation beyond the pandemic. For example:

- **Increased spending.** Telehealth waivers can increase spending in both programs, if telehealth services are furnished in addition to in-person services.
- **Program integrity.** The suspension of some program safeguards has increased the risks of fraud, waste, and abuse that GAO previously noted in its High-Risk report series.
- **Beneficiary health and safety.** Although telehealth has enabled the safe provision of services, the quality of telehealth services has not been fully analyzed.

Chairman Wyden, Ranking Member Crapo, and Members of the Committee:

Thank you for the opportunity to discuss flexibilities related to Medicare and Medicaid that were made available during the current public health emergency. More than a year after the Secretary of the Department of Health and Human Services (HHS) first declared a public health emergency for the U.S. and the World Health Organization characterized the Coronavirus Disease 2019 (COVID-19) as a pandemic, COVID-19 continues to result in catastrophic loss of life and substantial damage to the global economy, stability, and security.¹

In response to COVID-19, the Centers for Medicare & Medicaid Services (CMS), the federal agency responsible for overseeing Medicare and Medicaid, provided increased federal funding and made widespread use of program waivers and other flexibilities to expand the availability of services, maintain access for beneficiaries, and give providers more flexibility in treating beneficiaries. For example, CMS issued waivers to expand telehealth services in Medicare Fee-for-Service (FFS).² Many of these waivers and flexibilities CMS granted were to states, which administer their Medicaid programs within broad federal rules and according to state plans that CMS approves.

The CARES Act includes a provision for us to conduct monitoring and oversight of the federal government's efforts to prepare for, respond to, and recover from the COVID-19 pandemic.³ In response, we issued

¹On January 31, 2020, the Secretary of HHS declared a public health emergency for the U.S., retroactive to January 27. Subsequently, on March 13, 2020, the President declared COVID-19 a national emergency under the National Emergencies Act and a nationwide emergency under section 501(b) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (Stafford Act). See 50 U.S.C. § 1601 et seq. and 42 U.S.C. § 5121 et seq. The President has also approved major disaster declarations under the Stafford Act for all 50 states, the District of Columbia, and five territories.

²Medicare FFS consists of two separate parts: Medicare Part A, which primarily covers hospital services, and Medicare Part B, which primarily covers outpatient services. Medicare FFS beneficiaries may also enroll in Medicare Part D, which offers prescription drug coverage. Telehealth services include certain clinical services that are typically furnished in person but are instead provided remotely via telecommunications technologies. By law, Medicare FFS generally only pays for these services under limited circumstances; such as when the patient is located in certain health care settings and certain (mostly rural) geographic locations.

³Pub. L. No. 116-136, § 19010(b), 134 Stat. 281, 580 (2020).

government-wide reports on the federal efforts, have examined and reported on Medicare and Medicaid flexibilities during the pandemic, and we have ongoing work examining related topics such as Medicare and Medicaid telehealth waivers.⁴

My testimony today will summarize key findings from issued reports as well as preliminary observations from our ongoing work related to expanded telehealth services in the Medicare and Medicaid programs and flexibilities related to the provision of Medicaid home and community-based services during the COVID-19 pandemic.⁵ In particular, my statement will address

1. what is known about the effects of Medicare waivers on the Medicare Fee-for-Service program;
2. what is known about the effects of Medicaid waivers and flexibilities on the Medicaid program; and
3. considerations for the ongoing use of these waivers and flexibilities for Medicare and Medicaid.

In developing this statement, we relied primarily on reports we issued from June 2020 to March 2021. For our previously issued reports on which my comments are based, we reviewed applicable federal laws; CMS documents, including guidance on program waivers and guidance to states on resuming normal operations after the end of the public health emergency; CMS written responses to questions regarding Medicare waivers; and our prior work related to Medicare and Medicaid. We also interviewed Medicaid officials from selected states regarding flexibilities they requested during the COVID-19 pandemic.⁶ More detailed

⁴GAO, *COVID-19: Opportunities to Improve Federal Response and Recovery Efforts*, [GAO-20-625](#) (Washington, D.C.: June 25, 2020); GAO, *COVID-19: Urgent Actions Needed to Better Ensure an Effective Federal Response*, [GAO-21-191](#) (Washington, D.C.: Nov. 30, 2020); GAO, *COVID-19: Sustained Federal Action is Crucial as Pandemic Enters Its Second Year*, [GAO-21-387](#) (Washington, D.C.: Mar. 31, 2021).

⁵Medicaid home- and community-based services cover a wide range of services and supports to help individuals remain in their homes or live in a community setting, such as personal assistance with daily activities, assistive devices, and case management services to coordinate services and supports that may be provided from multiple sources.

⁶For more information about the scope and methods for our past work, please see our enclosures on Medicaid Enrollment, Spending, and Flexibilities; Medicaid Spending; Medicaid Financing, Waivers, and Flexibilities; Medicare Telehealth Waivers; and Medicare Waivers.

information on the scope and methodology for our past work can be found in these published reports.

My comments also include preliminary observations from ongoing work, including interviews with CMS officials and representatives from six beneficiary advocacy and provider groups, selected based on their experience with telehealth services and Medicare telehealth waivers, as well as Medicaid waivers and flexibilities.⁷ We reviewed CMS documents and other published research on the effects of Medicare telehealth waivers on these types of services during the pandemic. In particular, we reviewed a January 2021 report from CMS on the preliminary effects of some Medicare and Medicaid waivers on both programs—including the effect of telehealth waivers on Medicare utilization of services.⁸ We also reviewed data from the Kaiser Family Foundation on Medicaid waivers and flexibilities.⁹ We reviewed the utilization data and Medicaid waivers and flexibilities data for any obvious errors and determined these data were sufficiently reliable for the purpose of our objectives.

We shared our preliminary observations from this ongoing work with CMS officials to obtain their views. CMS officials provided us with technical comments, which we incorporated as appropriate.

We conducted the work upon which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

⁷The provider groups included umbrella organizations representing four broad specialty types—primary care, medical, surgical, and mental and behavioral health specialties. We also interviewed two beneficiary advocacy groups with knowledge of Medicare beneficiaries' experience with Medicare telehealth.

⁸See Centers for Medicare & Medicaid Services, *Putting Patients First: The Centers for Medicare & Medicaid Services' Record of Accomplishments from 2017-2020* (Jan. 13, 2021). We refer to this report as the CMS "Accomplishment Report" throughout this report.

⁹See Kaiser Family Foundation, *Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19*, accessed May 10, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>.

Background

Medicare Waivers and Flexibilities

In 2020, Medicare—the federally financed health insurance program for persons aged 65 or over, certain individuals with disabilities, and individuals with end-stage renal disease—spent about \$910 billion on health care services provided to about 62.8 million Medicare beneficiaries.¹⁰ Providers and suppliers furnishing services to beneficiaries must comply with Medicare requirements and conditions of participation that are set in statute and regulations. In response to COVID-19, CMS expanded the availability of Medicare services through widespread use of program waivers. Specifically, section 1135 of the Social Security Act authorizes the Secretary of HHS to temporarily waive or modify certain federal health care requirements, including in the Medicare program, to increase access to medical services when both a public health emergency and a disaster or emergency have been declared.¹¹ The Administrator of CMS typically implements section 1135 waivers for Medicare.

The president authorized HHS to issue waivers under section 1135 beginning March 1, 2020. This authority will end no later than the termination of one of the underlying emergencies or 60 days from the date the waiver is published, unless the Secretary extends it for additional periods of up to 60 days.

There are two types of Medicare 1135 waivers:

- **Blanket waivers** apply automatically to all applicable providers and suppliers in the emergency area, which encompasses the entire United States in the case of the COVID-19 pandemic. Providers and

¹⁰Total Medicare spending is for fiscal year 2020 and from the Centers for Medicare & Medicaid Services' Office of Financial Management. Count of Medicare beneficiaries is for calendar year 2020 and from the Centers for Medicare & Medicaid Services' Medicare Enrollment Dashboard. See <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMSProgramStatistics/Dashboard>; Accessed May 12, 2021.

¹¹See 42 U.S.C. § 1320b-5 (authority to waive requirements during national emergencies).

suppliers do not need to apply individually or notify CMS that they are acting upon the waiver. They are required to comply with normal rules and regulations as soon as it is feasible to do so.

- **Provider/supplier individual waivers** may be issued upon application for states, providers, or suppliers only if an existing blanket waiver is not sufficient.

Congress also enacted legislation to expand the Secretary's authority to temporarily waive or modify application of certain Medicare requirements, such as the geographic restrictions on where telehealth services can be provided. The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020, amends section 1135 of the Social Security Act to allow the Secretary to waive certain Medicare telehealth payment requirements during the emergency period.¹² The CARES Act further expands the Secretary's authority to waive telehealth requirements during the emergency period.¹³

Medicaid Waivers and Flexibilities

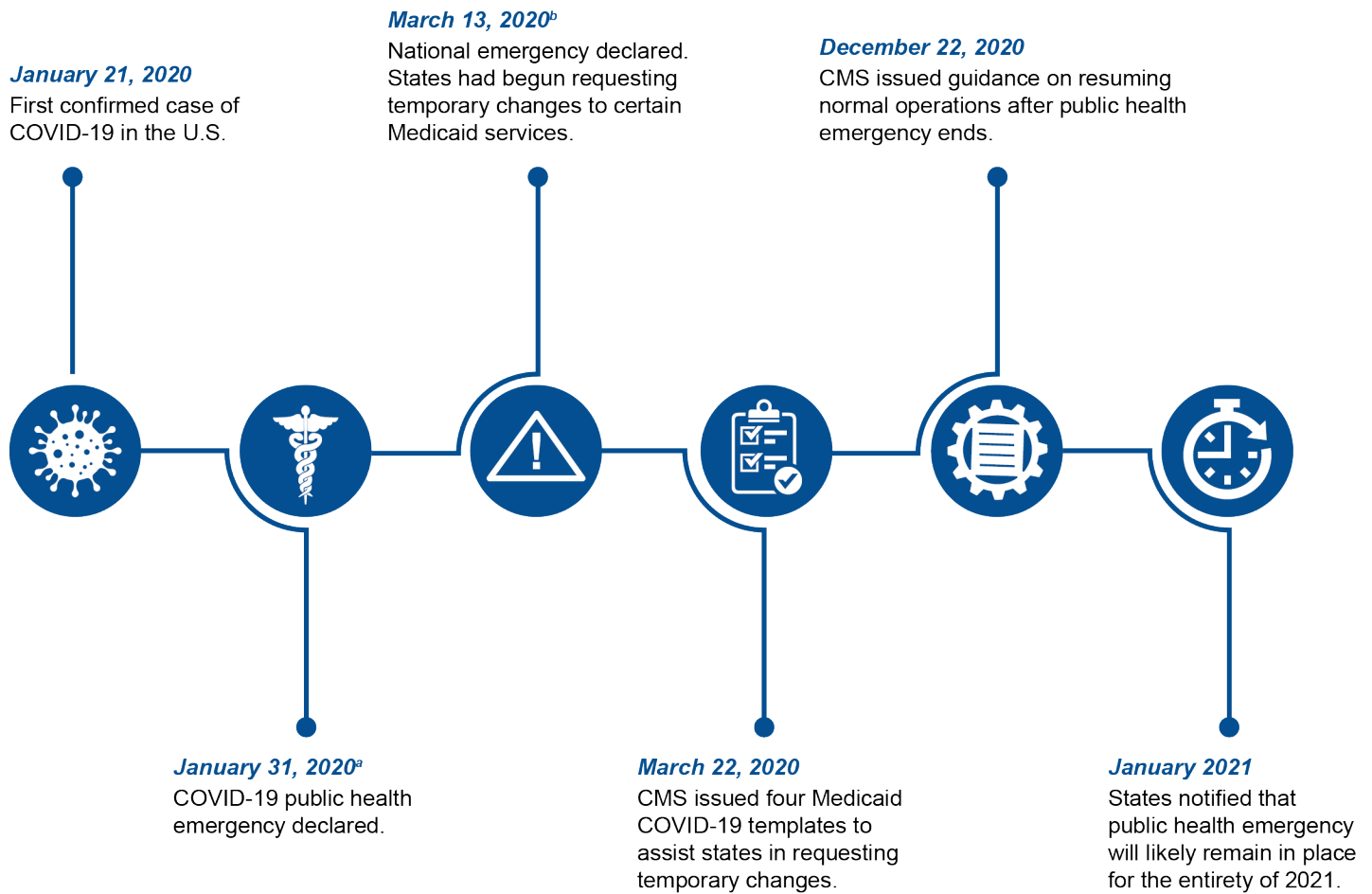
Medicaid is one of the nation's largest sources of funding for health care services for low-income and medically needy individuals, covering an estimated 77 million people and spending an estimated \$673 billion (total federal and state) in fiscal year 2020. Medicaid allows significant flexibility for states to design and implement their programs. For example, states can request waivers of certain federal requirements to target certain populations or to test new or innovative approaches for managing the health care needs of beneficiaries. In addition to its normal authority to approve these state waiver applications, CMS has additional authorities to waive Medicaid requirements to help ensure the availability of care in certain emergency circumstances.

Since the beginning of the COVID-19 pandemic, CMS has issued guidance to states on implementing various flexibilities and on resuming normal activities once the public health emergency has ended. (See fig.1.)

¹²Pub. L. No. 116-123, Div. B, § 102, 134 Stat. 146, 155-157 (adding 42 U.S.C. § 1320b-5(b)(8)).

¹³Pub. L. No. 116-136, § 3703, 134 Stat. 281, 416 (2020) (amending 42 U.S.C. § 1320b-5(b)(8)).

Figure 1: Selected CMS Medicaid Guidance to States during the COVID-19 Pandemic, January 2020 to January 2021



Legend: CMS=Centers for Medicare & Medicaid Services.

Source: GAO analysis of Department of Health and Human Services and CMS guidance. | GAO-21-575T

Text of Figure 1: Selected CMS Medicaid Guidance to States during the COVID-19 Pandemic, January 2020 to January 2021

- **January 21, 2020:** First confirmed case of COVID-19 in the U.S.
- **January 31, 2020^a:** COVID-19 public health emergency declared.
- **March 13, 2020^b:** National emergency declared. States had begun requesting temporary changes to certain Medicaid services.
- **March 22, 2020:** CMS issued four Medicaid COVID-19 templates to assist states in requesting temporary changes.

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- **December 22, 2020:** CMS issued guidance on resuming normal operations after public health emergency ends.
 - **January 2021:** States notified that public health emergency will likely remain in place for the entirety of 2021.

Note: Beyond the selected guidance noted in the figure, CMS officials have noted other steps related to states' implementation of various flexibilities. For example, CMS shared the Medicaid Disaster Relief Toolkit with states in March, 2020. According to CMS officials, the toolkit—first made available in August 2018—was designed for states and served as a foundation for available state flexibilities. CMS also held numerous all-state calls, as well as individual calls with each state and territory in early- to mid-March, 2020.

^aThe declaration of the public health emergency was retroactive to January 27, 2020.

^bThe declaration of the national emergency was retroactive to March 1, 2020.

For example, CMS created and released four templates to help states receive federal waivers and assist them in identifying other authorities to implement program flexibilities more efficiently. Specifically, CMS issued templates for four authorities for the following purposes:

- **Medicaid disaster state plan amendments:** To revise or implement new policies in Medicaid state plans related to eligibility, enrollment, benefits, premiums and cost sharing, or payments in response to a public health emergency or disaster.
- **Section 1115(a) demonstrations:** To furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who may be affected by COVID-19.¹⁴
- **Section 1135 waivers:** To temporarily waive or modify certain Medicaid requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse.
- **Section 1915(c), Appendix K waivers:** To request amendment to an approved section 1915(c) home and community-based waiver authority to respond to an emergency, for example, expanding the

¹⁴Under section 1115 of the Social Security Act, the Secretary of HHS may waive certain federal Medicaid requirements and approve expenditures that would not otherwise be eligible for federal Medicaid funds for certain experimental, pilot, or demonstration projects that, in the Secretary's judgment, are likely to promote Medicaid objectives.

pool of providers authorized to provide waiver services such as personal care.¹⁵

Full Effects of Medicare Waivers Not Yet Known; Preliminary Analysis Indicates Medicare Fee-for-Service Telehealth Waivers Increased Utilization and Access

CMS Has Issued Hundreds of Medicare Waivers During the COVID-19 Pandemic

According to the CMS Accomplishment Report, as of January 2021, CMS had issued over 130 blanket Medicare waivers nationwide since the start of the pandemic. The blanket waivers cover flexibilities for hospitals, skilled nursing facilities, home health agencies, and hospices, among others. They also cover flexibilities for providers, including licensing and enrollment, to the extent these flexibilities are consistent with applicable state laws, state emergency preparedness plans, and state scope of practice rules. For example, CMS waived or modified certain telehealth provisions to increase access to services and give providers more flexibility in treating beneficiaries.

In addition to blanket waivers of statutory requirements, CMS also reported that as of January 2021, it had issued over 100 Medicare waivers under its authority to waive or modify its policies or regulations in response to the pandemic. CMS has since made some of these waivers

¹⁵Under section 1915(c) of the Social Security Act, the Secretary of HHS may waive requirements that states offering home- and community-based services offer comparable benefits statewide and to all eligible beneficiaries, and that they use a single standard for eligibility.

permanent.¹⁶ Table 1 provides examples of changes that CMS approved, including under blanket waivers.¹⁷

Table 1: Examples of Medicare Waivers CMS Approved, Since March 13, 2020

Waiver	Changes
Increased capacity	<ul style="list-style-type: none"> Expand hospital capacity—for example, hospitals may provide patient care at nonhospital buildings or spaces provided that the location is approved by the state, and hospitals may treat patients in their own homes.^a Allow hospitals to set up alternative screening sites on campus to perform medical screening examinations as a triage function.^b Waive sanctions for certain referrals that would otherwise violate the Physician Self-Referral law that generally prohibits a physician from making referrals for certain health care services to an entity with which the physician (or an immediate family member) has a financial relationship, unless an exception applies.^c
Workforce expansion	<ul style="list-style-type: none"> Expedite process for provider enrollment in Medicare, including expediting pending or new applications and waiving certain criminal background checks. Allow physicians whose privileges to practice at a hospital will expire to continue practicing at the hospital and allowing new physicians to begin practicing before full approval.
Reducing administrative burdens	<ul style="list-style-type: none"> Temporarily eliminate certain reporting and other paperwork requirements that providers must complete to be paid by Medicare, such as program audits that may require additional information from providers.
Expansion of telehealth services	<ul style="list-style-type: none"> Allow telehealth services to be provided nationwide, rather than only in certain locations. Allow beneficiaries to receive, and providers to furnish, telehealth services from any setting, including beneficiaries' and providers' homes. Allow additional types of providers, such as physical and occupational therapists, to furnish telehealth services. Temporarily add over 146 new telehealth services. Allow certain services to be furnished using audio-only technology such as telephones, instead of interactive systems involving video technology.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information. | GAO-21-575T

^aHospitals typically must meet certain requirements to participate in Medicare, including providing services within their own buildings.

^bBy law, any Medicare-participating hospital with a dedicated emergency department must provide a medical screening examination and, if necessary, stabilizing treatment to any individual who arrives in its emergency department for examination or treatment, regardless of the ability to pay for the services.

^cEntities that submit claims for services furnished pursuant to a prohibited referral are subject to financial sanctions.

¹⁶For example, in December 2020, CMS announced it was permanently adding certain new services (including mental health and care planning services) that it had temporarily added to the approved list of Medicare telehealth services during the pandemic.

¹⁷For more information on all COVID-19 related waivers approved by CMS, see Centers for Medicare & Medicaid Services, *Coronavirus Waivers and Flexibilities*, accessed May 11, 2021, <https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers>.

Full Effects of Medicare Waivers Are Not Yet Known

Information on the full effects of Medicare waivers and flexibilities is not yet available. However, in its Accomplishment Report, CMS provided information on certain flexibilities in January 2021. For example:

- **Expansion of hospital capacity.** CMS reported that the waiver permitting hospitals to use non-hospital buildings and spaces to be used for patient care and quarantine sites (subject to state approval), has expanded access to care during the pandemic. For example, according to CMS, as of January 2021, 116 facilities in Texas were enrolled as hospital sites under a waiver that allowed ambulatory care centers and freestanding emergency centers to enroll as hospitals—thus increasing access to care. Additionally, CMS reported as of January 7, 2021, it had approved 63 hospitals in 21 states nationwide to participate in the waiver that allowed hospitals to treat patients in their own homes.¹⁸
- **Workforce expansion.** CMS reported that the removal of certain barriers regarding licensure and scope of practice has expanded the provider workforce enabling health professionals to provide services they were otherwise not eligible to provide, subject to state law. For example,
 - Certain non-physician practitioners such as nurse practitioners and physician assistants can supervise the performance of diagnostic tests, subject to state law.
 - Occupational therapists from home health agencies can now perform initial assessments on certain homebound patients, allowing home health services to start sooner and freeing home-health nurses to do more direct patient care.

However, the Accomplishment Report did not contain information on the extent to which these added flexibilities have resulted in greater access to services for Medicare beneficiaries.

CMS's Accomplishment Report also did not contain information on the effects of other flexibilities—including waivers granting provider enrollment flexibilities or waivers that reduced administrative burdens—on

¹⁸These include six health systems with extensive pre-pandemic experience providing acute hospital care at home—Brigham and Women's Hospital (Massachusetts); Huntsman Cancer Institute (Utah); Massachusetts General Hospital (Massachusetts); Mount Sinai Health System (New York City); Presbyterian Healthcare Services (New Mexico); and UnityPoint Health (Iowa).

Medicare services during the pandemic. In future work, we will examine the impact of these and other waivers and flexibilities that HHS issued in response to the pandemic.

Medicare Telehealth Waivers Increased Utilization and Access

As we reported in November 2020, Medicare telehealth waivers resulted in increased utilization of telehealth services, and provided beneficiaries access to services that would not have otherwise been available during the early days of the COVID-19 pandemic. However, the long-term effect of these waivers on spending and quality of care is not yet known.¹⁹ In addition, we reported that careful monitoring and oversight is warranted to prevent potential fraud, waste, and abuse that can arise from these new waivers. Existing research and preliminary observations from our ongoing work indicate the following effects of telehealth waivers on service utilization and access to care.

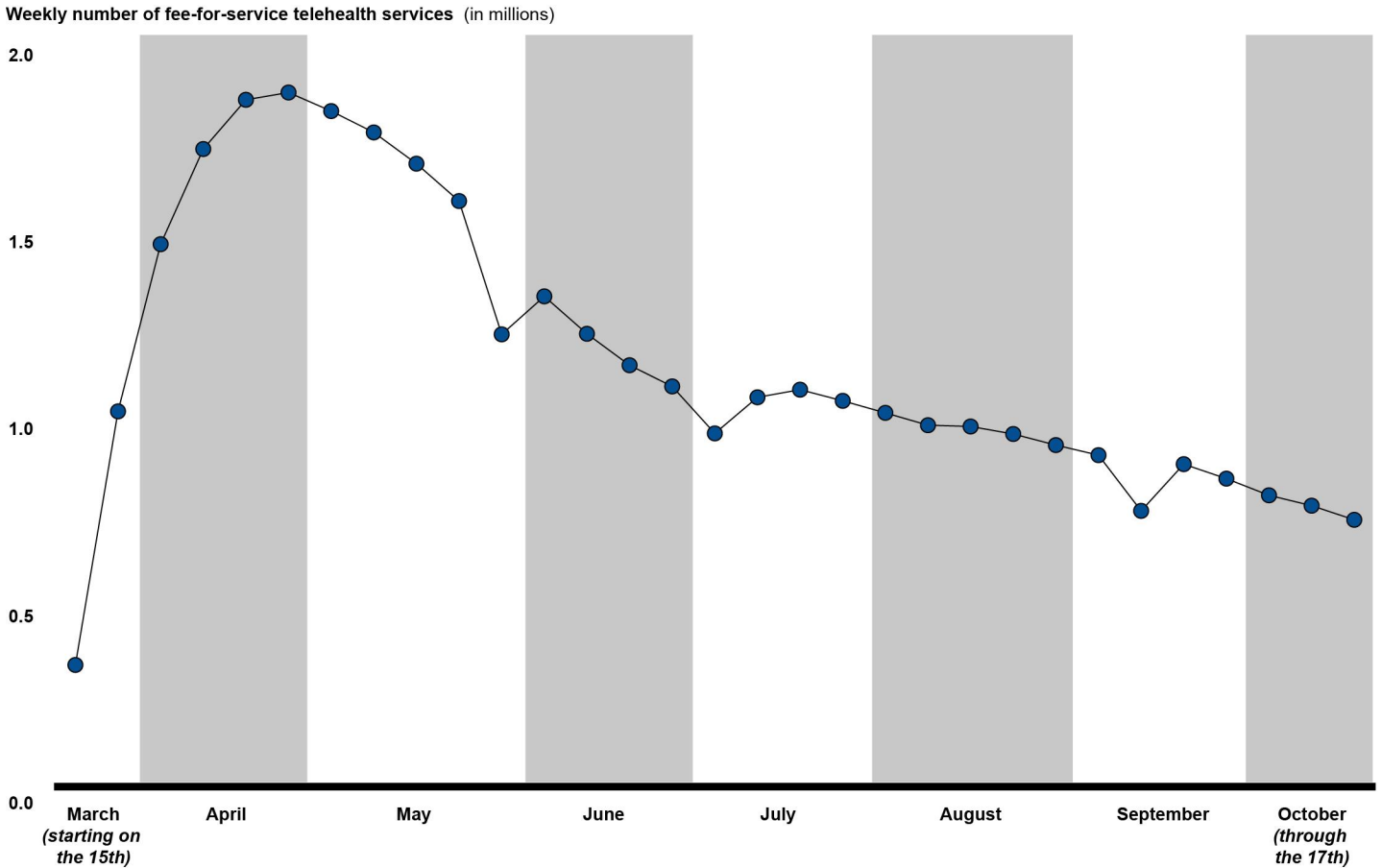
Available analysis from the CMS Accomplishment Report indicates that over the first 8 months of the pandemic, utilization of telehealth services in Medicare FFS sharply increased from about 325,000 services in mid-March to a peak of nearly 1.9 million services in late-April.²⁰ Utilization then dropped to about 1.3 million services by the beginning of June, and

¹⁹See [GAO-21-191](#).

²⁰The data for this analysis are based on Medicare FFS claims submitted through 11/13/2020. These figures include telehealth services as well as other services such as virtual check-ins and e-visits, which collectively CMS defines as telemedicine. Virtual check-ins are short patient-initiated communications with a health care practitioner through different technologies including by phone or video. E-visits are non-face-to-face patient-initiated communications through an online patient portal. Medicare covered and paid for virtual check-ins and e-visits prior to the pandemic.

generally continued to slowly drop through mid-October, as shown in figure 2.²¹

Figure 2: Medicare Weekly Utilization of Telehealth Services from March 15 through October 17, 2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-575T

²¹CMS did not provide data on corresponding utilization of in-person services for all services furnished via telehealth during this time. An analysis of telehealth utilization of primary care services from the Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation showed similar trends in telehealth utilization. Their analysis also showed that while telehealth primary care services were peaking from mid-March through mid-April, in-person services were precipitously dropping during this time, and that the peak in telehealth services was not sufficient to offset the drop in in-person services. See Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Medicare Beneficiary Use of Telehealth Visits: Early Data from the Start of COVID-19 Pandemic* (Washington, D.C.: July 28, 2020).

Data table for Figure 2: Medicare Weekly Utilization of Telehealth Services from March 15 through October 17, 2020

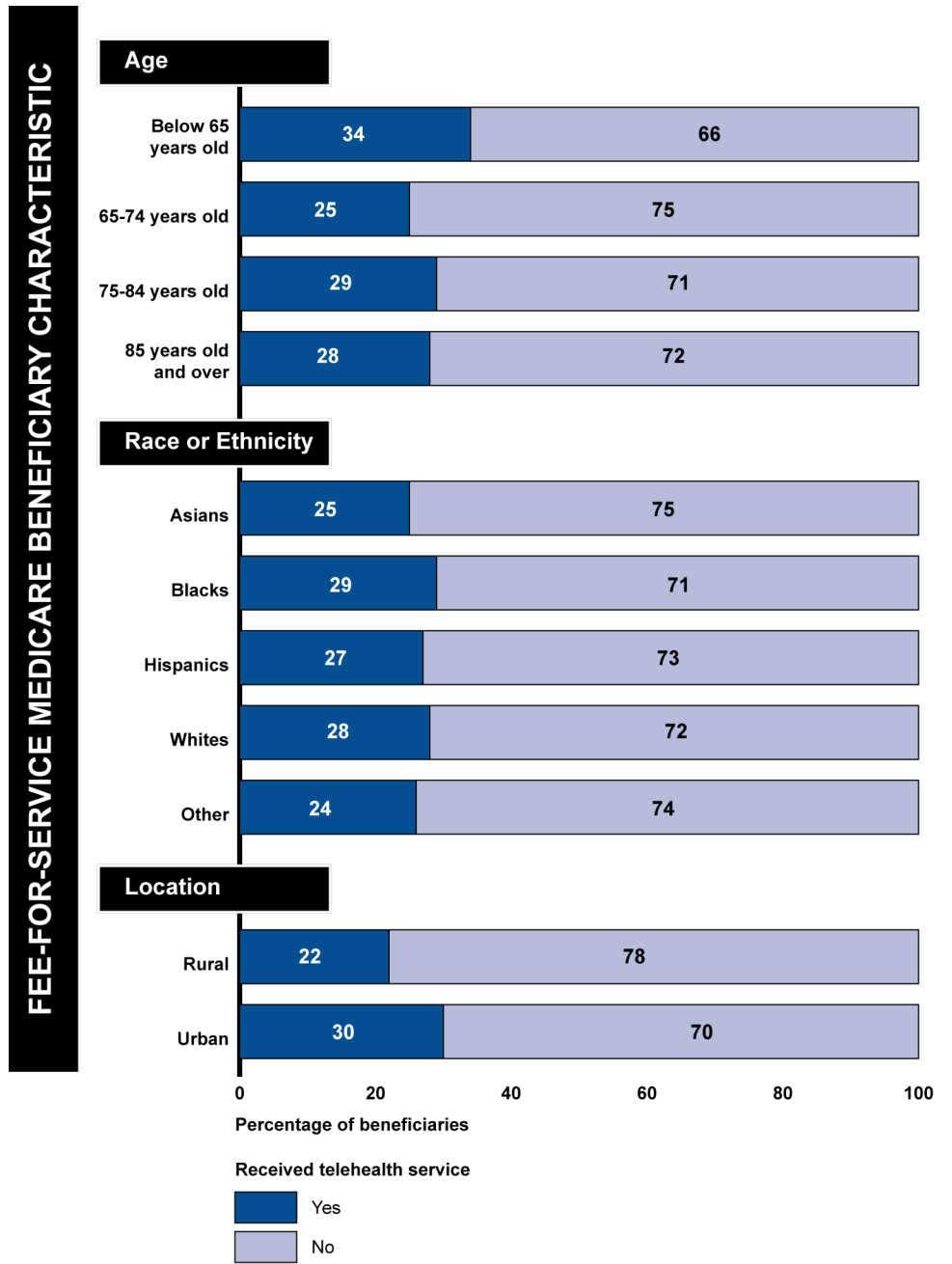
	Week Ending	All Telehealth Total
March 2020 (starting on the 21st)	21-Mar	325,441
March	28-Mar	1,003,577
April	4-Apr	1,450,686
April	11-Apr	1,705,115
April	18-Apr	1,836,806
April	25-Apr	1,856,248
May	2-May	1,806,612
May	9-May	1,749,505
May	16-May	1,665,911
May	23-May	1,566,009
May	30-May	1,209,471
June	6-Jun	1,311,119
June	13-Jun	1,210,974
June	20-Jun	1,126,945
June	27-Jun	1,070,277
July	4-Jul	944,635
July	11-Jul	1,041,199
July	18-Jul	1,061,565
July	25-Jul	1,031,787
August	1-Aug	999,577
August	8-Aug	966,560
August	15-Aug	963,140
August	22-Aug	943,060
August	29-Aug	913,390
September	5-Sep	886,446
September	12-Sep	737,497
September	19-Sep	862,427
September	26-Sep	823,685
October	3-Oct	779,094
October	10-Oct	751,363
October (through the 17th)	17-Oct	713,577

Note: The data for this analysis are based on Medicare fee-for-service claims submitted through 11/13/2020. These figures include telehealth services as well as other services such as virtual check-ins and e-visits, which collectively CMS defines as telemedicine. Virtual check-ins are short patient-initiated communications with a health care practitioner through different technologies including by phone or video. E-visits are non-face-to-face patient-initiated communications through an online patient portal. Medicare covered and paid for virtual check-ins and e-visits prior to the pandemic.

This utilization varied by the type of service, the specialty of the provider, and the telehealth modality (audio-video or audio only). For example, CMS reported that nearly 40 percent of beneficiaries receiving office visits received them through telehealth compared to nearly 60 percent for mental health services. CMS also reported that internists and family practitioners furnished about one-quarter of their services through telehealth compared to virtually none for other specialties. In addition, CMS reported that many (89 out of 146) of the newly available types of telehealth services could be furnished through landline phones.

Moreover, CMS reported that telehealth waivers played a critical role in maintaining access to services when beneficiaries and providers were concerned about the transmission of COVID-19. For example, before the pandemic, approximately 13,000 beneficiaries in Medicare FFS had received telehealth services in a week, compared to almost 1.7 million in the last week of April. CMS also reported that there was some variation in the levels of access among various groups of beneficiaries utilizing telehealth services. For example, a slightly higher proportion of beneficiaries below the age of 65 received a telehealth service, compared to groups aged 65 and over; the proportion of beneficiaries receiving telehealth services in urban areas was slightly higher than in rural areas; but the proportion of beneficiaries utilizing telehealth was similar across racial and ethnic groups. (See fig. 3.)

Figure 3: Percentages of Medicare Fee-for-Service Beneficiaries Receiving Telehealth Services, by Beneficiary Characteristics, March 17 through June 13, 2020



Source: GAO analysis of Centers for Medicare & Medicaid Services data. | GAO-21-575T

Data table for Figure 3: Percentages of Medicare Fee-for-Service Beneficiaries Receiving Telehealth Services, by Beneficiary Characteristics, March 17 through June 13, 2020

Beneficiary Age	Yes accessed telehealth	No
Below 65	34%	66%
65-74	25%	75%
75-84	29%	71%
Older than 85	28%	72%

Beneficiary Race or Ethnicity	Yes accessed telehealth	No
Asians	25%	75%
Blacks	29%	71%
Hispanics	27%	73%
Whites	28%	72%
Other	26%	74%

Beneficiary Lives in Rural or Urban Area	Yes accessed telehealth	No
Rural	22%	78%
Urban	30%	70%

Note: These figures include telehealth services as well as other services such as virtual check-ins and e-visits, which collectively CMS defines as telemedicine. Virtual check-ins are short patient-initiated communications with a health care practitioner through different technologies including by phone or video. E-visits are non-face-to-face patient-initiated communications through an online patient portal. Medicare covered and paid for virtual check-ins and e-visits prior to the pandemic.

Preliminary observations from our interviews with groups representing providers and beneficiaries confirmed flexibilities enabled beneficiaries to continue accessing care. Specifically, representatives we interviewed from two provider groups said providers quickly adopted and furnished telehealth services in the early days of the pandemic, but as patients became more comfortable coming into the office or clinic, in-person appointments resumed. Representatives from one provider group also told us that they relied more heavily on audio-only or phone visits rather than video visits in the early days of the pandemic and switched later on to offering only in-person or video visits. Interviews with two groups representing beneficiaries indicated that telehealth flexibilities have enabled beneficiaries to access care from home during the pandemic, as

well as the ability to seek care in a timely manner, reduce travel time, and triage their health issues to determine if an in-person visit is needed.

However, as we noted in our June 2020 report, telehealth waivers may not alleviate all access concerns.²² Further, a recent study found that more than 26 percent of Medicare beneficiaries lack digital access at home in 2018, making it unlikely that they could have video-based telehealth visits with clinicians.²³ The proportion of beneficiaries in this study who lacked digital access was higher among those with low socioeconomic status, those 85 years or older, and in communities of color. Preliminary observations from our beneficiary and provider group interviews is consistent with these findings. For example, representatives from the two beneficiary groups and three groups representing providers told us that some beneficiaries were unable to access telehealth services due to lack of technology or broadband needed for a telehealth visit or they did not understand how to use the technology.

Furthermore, the quality of telehealth services provided to Medicare beneficiaries has not yet been fully analyzed, and evidence from the few existing studies is inconclusive. According to MedPAC, some researchers have concluded that, in addition to increasing access to care, telehealth can also improve the quality of care.²⁴ Other researchers caution that the convenience of telehealth could harm the quality of patient care.²⁵ CMS officials told us in February 2021 that they are still exploring how to measure the quality of care when services are delivered via telehealth.

²²See [GAO-20-625](#).

²³Eric Roberts and Ateev Mehrotra, "Assessment of Disparities in Digital Access Among Medicare Beneficiaries and Implications for Telemedicine," *The Journal of American Medical Association Internal Medicine*, vol. 180, no. 10 (2020): pp. 1386–1389.

²⁴For example, in 2018 MedPAC reported that telestroke services both expanded access to care and likely improve the quality of care because the timeliness of stroke treatment could be improved. MedPAC, Report to Congress: Medicare Payment Policy (March 2018): 496.

²⁵For example, a 2015 study of patients receiving treatment for acute respiratory infections found that physicians providing care through telehealth prescribed more expensive antibiotics that could increase antibiotic resistance in patients than antibiotics prescribed by physicians providing in-person care. See L. Uscher-Pines, et al., *Antibiotic Prescribing for Acute Respiratory Infections in Direct-to-Consumer Telemedicine Visits*, *JAMA Internal Medicine*, vol. 175, no.7. (2015).

Temporary State Medicaid Flexibilities Aimed to Address Obstacles to Beneficiary Care, Provider Availability, and Program Enrollment; Effects Not Fully Known

CMS-approved Medicaid waivers and flexibilities in all states were aimed at addressing obstacles that affect beneficiary care and provider availability, among other areas. In December 2020, CMS reported that the agency had approved more than 600 different Medicaid waivers, state plan amendments, and other flexibilities to offer states flexibility in responding to the COVID-19 pandemic. Some of the Medicaid flexibilities focused on facilitating beneficiary access to care and beneficiary safety. For example, CMS approved flexibilities regarding the provision of long-term services and supports to beneficiaries who receive care in facilities or in their homes and who were particularly vulnerable to exposure and disease. Other flexibilities focused on ensuring provider availability, such as allowing licensed out-of-state providers to enroll in a state’s Medicaid program. (See table 2.)

Table 2: Examples of State Medicaid Waivers and Flexibilities Approved by CMS, March 2020 to May 2021

Focus	Specific state flexibilities approved
Beneficiary care and safety	<ul style="list-style-type: none"> • Forty-three states suspended fee-for-service prior authorizations, which are used to demonstrate compliance with coverage and payment rules before beneficiaries can obtain certain services, rather than after the services have been provided.^a • Forty-nine states extended the dates for reassessing and reevaluating beneficiaries’ needs, which are normally required for beneficiaries to retain eligibility for some home- and community-based services.^b • Fifty states permitted virtual evaluations, assessments, and person-centered planning for beneficiaries receiving long-term services and supports normally conducted in person.^b • Fifty-one states issued program guidance to expand coverage and access to telehealth services.^c • Nine states allowed early refills for most medications.^c
Provider availability	<ul style="list-style-type: none"> • Fifty-one states waived some requirements to allow licensed out-of-state providers to enroll in their programs to maintain provider capacity.^{a,d} • Twelve states modified facility requirements to allow services to be provided from practitioner’s location via telehealth.^c • Fifty-one states waived certain provider screening and enrollment requirements during the pandemic.

Source: GAO analysis of Centers for Medicare & Medicaid Services (CMS) information compiled by Kaiser Family Foundation, Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19, accessed May 10, 2021, <https://www.kff.org/coronavirus-covid-19/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>. | GAO-21-575T

Note: For purposes of the table, states include the 50 states and the District of Columbia.

^aStates received approval under section 1135 of the Social Security Act, which authorizes the Secretary of Health and Human Services to temporarily waive or modify certain federal health care program requirements, including Medicaid requirements, to ensure that sufficient health care items

and services are available to meet the needs of enrollees when both a public health emergency and a disaster or emergency have been declared.

^bStates received approval to make changes to their section 1915(c) home- and community-based services waivers under an Appendix K amendment in order to respond to the emergency.

^cStates received approval to revise policies in their Medicaid state plan related to eligibility, enrollment, benefits, premiums and cost sharing, and payments. To make these changes, states must submit a State Plan Amendment to CMS for approval.

^dStates approved to temporarily enroll licensed out-of-state providers must follow certain requirements, which include screening providers to ensure they are enrolled in the Medicaid program and licensed in the state relating to their Medicaid enrollment. Waiver of these federal requirements does not affect state or local licensure requirements.

Among these flexibilities, we have reported that efforts to remove obstacles to beneficiary access to care, such as the use of telehealth, were among the most important during the COVID-19 pandemic.²⁶ A Medicaid official we interviewed in one state said that flexibilities permitting virtual evaluations provided Medicaid beneficiaries with an added sense of security and safety while providing needed care. We have ongoing work examining states' experiences using waivers to maintain safe access to home- and community-based services. To reduce in-person contact between beneficiaries and providers, CMS has approved waivers allowing family to become paid caregivers. In addition, waivers have been used to make retainer payments to certain providers to support and maintain the provider network.

In addition to waivers, recent statutory changes have aimed at maintaining Medicaid enrollment. For example, the Families First Coronavirus Response Act provided a temporary increase in the federal government's matching rate for states' and territories' spending for Medicaid services for all qualifying states through the end of the quarter in which the public health emergency, including any extensions, ends. To receive the increased matching rate, states and territories were required to meet certain conditions, such as maintaining Medicaid enrollment for certain beneficiaries through the end of the month in which the public health emergency ends.²⁷ In March 2021, we reported that from February

²⁶See [GAO-21-387](#).

²⁷Specifically, states must provide continuous coverage to Medicaid beneficiaries who were enrolled in Medicaid on or after March 18, 2020, regardless of any changes in circumstances or redeterminations at scheduled renewals that otherwise would result in termination, through the end of the month in which the public health emergency ends, among other requirements. States may terminate coverage for individuals who request a voluntary termination of eligibility, or who are no longer considered to be residents of the state.

2020 through August 2020, Medicaid enrollment increased by 5.6 million, or 9 percent.²⁸

Some preliminary effects of CMS-approved waivers and flexibilities and other flexibilities states permitted through law are known. CMS has reported an increase in telehealth utilization since the pandemic began—in particular, soon after the national emergency was declared. CMS has also reported variation in the use of telehealth across states and across ages within states.²⁹ As an example of this variation, in January 2021, a North Carolina Medicaid official reported that beneficiaries in urban geographies were more likely to use services delivered via telehealth than beneficiaries in rural geographies.

Program Integrity, Beneficiary Health and Safety, and Equity Are Among Considerations for the Continued Use of Waivers and Flexibilities Implemented during the Pandemic

The waivers and flexibilities implemented in Medicare and Medicaid during the COVID-19 pandemic likely benefitted providers and beneficiaries, yet determining whether—and if so, how—to continue them post-pandemic warrants consideration. CMS has made some Medicare waivers permanent, and, based on interest from policy-makers and stakeholders, is considering doing so for other waivers. With respect to Medicaid, CMS has set an end date for some of the waivers and flexibilities and has issued guidance to states in December 2020 on resuming normal Medicaid operations after the end of the public health emergency.³⁰ In light of these impending decisions, our past work and the work of others suggest there are several issues, including program integrity, beneficiary health and safety, and equity, to consider.

²⁸See [GAO-21-387](#).

²⁹See CMS, *Medicaid and CHIP COVID-19 Summaries, Preliminary Medicaid & CHIP Data Snapshot of Services through July 31, 2020*, accessed May 10, 2021, <https://www.medicaid.gov/state-resource-center/downloads/covid19-data-snapshot.pdf>.

³⁰See CMS, *RE: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency* (Baltimore, MD: Dec. 22, 2020).

Potential for increased spending. As we have previously reported, telehealth and other waivers pose risks of increased spending in both programs. Specifically,

- Recent data from the CMS Accomplishment Report indicates telehealth services continued as in-person visits began to ramp up in the third quarter of 2020. This suggests that increased demand for telehealth may continue even after the pandemic—an important consideration given payment incentives that may result from paying the same for telehealth and in-person services. One provider group that we interviewed also noted that these incentives may be particularly relevant for specialties that can provide and be paid for both in-person and additional telehealth services they generate compared to other procedure-based specialties that receive more global payments regardless of the number of visits they generate.
- The temporary waiver of sanctions for certain referrals that would otherwise violate the Physician Self-Referral Law may increase the potential for increased spending in both programs given our prior work indicating that providers who self-refer tended to use more health care services.³¹

Program integrity. Both the Medicare and Medicaid programs are on GAO's High-Risk List, in part due to concerns about fraud, waste, and abuse.³² Increased program spending, the lack of complete data, and suspensions of some program safeguards increase these risks. For example:

- CMS lacks complete data to determine the telehealth modality being used (audio only or audio-video technology) or if services are originating from providers' and beneficiaries' homes, important information to consider in light of the aforementioned payment

³¹GAO, *Medicare Physical Therapy: Self-Referring Providers Generally Referred More Beneficiaries but Fewer Services per Beneficiary*, [GAO-14-270](#) (Washington, D.C.: Apr. 30, 2014); GAO, *Medicare: Higher Use of Costly Prostate Cancer Treatment by Providers Who Self-Refer Warrants Scrutiny*, [GAO-13-525](#) (Washington, D.C.: July 19, 2013); GAO, *Medicare: Action Needed to Address Higher Use of Anatomic Pathology Services by Providers Who Self-Refer*, [GAO-13-445](#) (Washington, D.C.: Jun. 24, 2013); GAO, *Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny*, [GAO/HEHS-95-2](#) (Washington, D.C.: Oct. 20, 1994).

³²GAO, *High-Risk Series: Dedicated Leadership Needed to Address Limited Progress in Most High-Risk Areas*, [GAO-21-119SP](#) (Washington, D.C.: Mar. 2, 2021).

incentives and that the quality of telehealth services has not yet been fully analyzed.

- The non-enforcement of certain privacy and security rules to allow for telehealth flexibility raises concerns about the transmission of medical information over potentially insecure systems.³³

In our ongoing work, CMS officials have noted oversight activities related to program integrity. As examples:

- CMS is using its Fraud Prevention System to identify potentially inappropriate Medicare claims for telehealth services prior to payment and to flag providers with suspicious billing patterns through post-payment screens.
- CMS is conducting and updating program integrity risk assessments for all Medicaid waivers and flexibilities issued as a result of the pandemic.

Beneficiary health and safety. Providing services while limiting beneficiary exposure to COVID-19 has been a difficult balance for CMS and states—and telehealth has been a large part of these efforts. The pandemic has also given rise to new levels of need for behavioral health care—both mental health and substance use disorders—while behavioral health service providers reported increasing demand and decreasing staff size.³⁴ Extending or ending waivers and flexibilities may affect beneficiary health and safety in unknown ways.

- In Medicare, we have previously reported that the effect of COVID-19 related waivers on quality of care is not yet known. We also noted earlier that the quality of telehealth services has not been fully analyzed, and evidence from the few existing studies is inconclusive.
- In Medicaid, preliminary data from CMS show outpatient mental health services for adults age 19 to 64 declined starting in March and continuing through July—despite CMS approving waivers and flexibilities to help ensure the availability of care.

³³The HHS Office of Civil Rights (responsible for enforcing certain regulations relating to privacy and security of protected health information) stated that it would exercise enforcement discretion and not impose penalties for noncompliance with regulatory requirements during the pandemic.

³⁴GAO, *Behavioral Health: Patient Access, Provider Claims Payment, and the Effects of the COVID-19 Pandemic*, [GAO-21-437R](#) (Washington, D.C.: Mar. 31, 2021).

- Expedited processes for provider enrollment, including waivers of normal screening and criminal background checks, could affect the quality of care provided to beneficiaries in both programs.

Issues of equity. We have previously reported that communities of color have been disproportionately affected by COVID-19 in terms of cases reported, hospitalizations, deaths, and rates of testing and vaccinations.³⁵ Disparate effects from COVID-19 extend to beneficiaries' receipt of services, as well. As we noted earlier, beneficiaries in urban areas received or were more likely to use telehealth services than beneficiaries in rural areas both in Medicare and in one state's Medicaid program. To ensure that all beneficiaries receive the best care possible, how waivers and flexibilities in both programs account for equity is an important consideration.

In summary, my testimony highlighted the various flexibilities and waivers implemented during the COVID-19 pandemic and provided preliminary information on how these flexibilities have likely benefitted providers and beneficiaries. Continuing these flexibilities after the public health emergency declarations end could increase certain risks to the Medicare and Medicaid programs. Careful consideration of these benefits and risks will be key to determining the path forward, especially given that both programs are on GAO's High-Risk List. We look forward to working with Congress as we continue our oversight of the federal response to the COVID-19 pandemic.

Chairman Wyden, Ranking Member Crapo, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgments

If you or your staff have any questions about this testimony, please contact Jessica Farb, Director, Health Care at farbj@gao.gov or Carolyn Yocom, Director, Health Care at yocomc@gao.gov or both can be reached at (202) 512-7114. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. GAO staff who made key contributions to this testimony

³⁵For example, Non-Hispanic Black persons were hospitalized at almost 3 times the rate of non-Hispanic White persons when adjusting for age, and their death rates were 1.4 times higher than non-Hispanic White persons. See [GAO-21-387](#).

Letter

were Iola D'Souza (Assistant Director), Maggie Holihan (Analyst-in-Charge), Susan Anthony (Assistant Director), Susan Barnidge (Assistant Director), Rob Dougherty, Nancy Fasciano, Madison Herin, Peter Mangano, and Kimberly Perrault. Also contributing were Cathy Hamann and Vikki Porter.

Related GAO Reports

GAO, Medicare: Referrals to Physician-Owned Imaging Facilities Warrant HCFA's Scrutiny, [GAO/HEHS-95-2](#) (Washington, D.C.: Oct. 20, 1994).

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