Telehealth – Reimbursement and Policy
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Conflict of Interest

Krista Drobac, M.P.P.

Has no real or apparent conflicts of interest to report.
Agenda

• Learning Objectives
• Market Landscape & Outlook
• Evidence of Cost Savings & Quality Care
• Legislative & Regulatory Barriers
Learning Objectives

• Identify current trends in public and private sector adoption of connected care technologies

• Explain current regulatory and legislative issues that are impacting connected health adoption

• Discuss opportunities for continued improvements to reimbursement policies for telemedicine and remote patient monitoring
Value of Health STEPS

• Telemedicine and remote patient monitoring have demonstrated integral roles in several STEPS™ value categories.
• In this presentation the following areas will be highlighted:
  – Satisfaction
  – Patient Engagement and Population Health Management
  – Savings
Alliance for Connected Care

Background:

- Formed in December 2013
- 501(c)(6) organization
- Focused on creating a statutory and regulatory environment that allows that increases appropriate payment to providers and access for patients
- Alliance members are committed to safe, high quality care using connected care technology regardless of geographic delivery location or technological modality.

Board, Associate & Partner Members:

- Anthem
- CVS Health
- Teladoc
- Intel
- MDLIVE
- Avizia
- Care Innovations
- CareSpan
What is Telemedicine?

**Asynchronous Communication**
- E-mail communication
- Passive, remote monitoring through in-home sensors
- Access to LPN, RN or MD

**Virtual Communication**
- Phone consult or online video in real time
- Devices: • Computer; • Smartphone; or • Tablet

**Live + Virtual Communication**
- Kiosk or retail clinic model with patients connect to NP via online video in real-time
- Differentiation is that the LPN/LVN acts as the “hands” of the remote NP
- Real-time: • Vaccinations; • Blood tests; and • Other basic services

**Store & Forward**
- Allows for the electronic transmission of medical information
- Examples: • Digital images; • Documents; and • Pre-recorded videos through secure email transmission

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What is Telemedicine?
Telemedicine Goes Mainstream
Telemedicine Offerings Increasing Among Employers

A survey conducted of 140 employers with 10,000 or more employees found rapid growth in telemedicine options.

- 28% in 2014
- 48% in 2015
- 74% in 2016 (Projected)

National Business Group on Health “Large Employers’ 2016 Health Plan Design Survey.”
Investing in Telehealth

**Hospital Providers**
- A recent survey of hospital executives found 60% found telehealth a top priority for their organizations.
  - 34% said the programs were “under consideration” or in development
  - 18% were in the optimization phase
  - 16% were being piloted
  - 18% were being implemented.
  - Just 8% of respondents said they had no program at all

**Health Plans**
- **Anthem**
  - In 2013, Anthem was first to invest heavily in telehealth, but all major plans have quickly followed.
  - Currently Anthem provides services to 13 million members with plans to increase to 20 million.
- **BCBS Association**
  - In October 2015, American Well announced a partnership with 29 Blue Cross Blue Shield plans serving 26 states.
- **Aetna**
  - Partnered with Teladoc in 2011.
  - The partnership has grown to 160 health plan sponsors.
  - Currently looking to expand to behavioral health providers.
Marketplace Outlook

Various market research organizations peg the telehealth market growth rate between 18-30% per year.

The telemedicine U.S. market generated annual revenue of $645 million in 2015.

The telemedicine market in the U.S. is expected to grow to over $13 billion by 2021.

Why the Explosive Growth?

- Consumers are demanding more convenient care
- Employers & plans looking for new ways to reduce costs
- Telehealth offerings are more sophisticated
- User satisfaction with telehealth is very high
Consumers Are Interested in Telehealth

64% of consumers would choose a video-based virtual visit.

70% of patients prefer to get common prescriptions via video visits.

61% of consumers preferred telehealth because of the convenience.

Consumer Demand for Telehealth

Consumer Satisfaction with Telehealth

• CVS Survey of Consumers Using Telehealth
  – Of the 1,734 respondents, 70 percent were women and 40 percent had no other primary doctor.
  – Participants were asked to rate their satisfaction with different parts of the telehealth visit, and then were asked whether they preferred it to an in-person visit, found it the same, or liked it less.

• Preference for Telehealth
  – Women were more likely to prefer telehealth, as were people without insurance and people who gave telehealth high scores for quality of care and convenience.

• Satisfaction
  – More than 95 percent of respondents were highly satisfied with quality of care they received, the ease with which technology was integrated into the visit, and the timeliness and convenience of their care.

Evidence is Key

- Data shows the importance of Connected Care to the bottom line issues of quality, patient satisfaction and cost.
- Investment in telehealth and remote patient monitoring will yield results.
- Commissioned literature review from two professors: Dr. Rashid Bashshur of University of Michigan and Dr. Gary Shannon of University of Kentucky.
- Looked at actuarial analysis of substitution rates.
- Looked at disease incidence, cost of disease, review of how telemedicine is typically applied to the disease.
Primary Care: Substitution

- Virtual visits are not simply a supplement to in-person visits.
- Data shows that 83% of the time patient issue is resolved by telehealth.
- Telehealth also helped avoid urgent care visits by 55%.
- The average number of telehealth visits per patient is 1.3 visits/year.
- Replacing in-person acute care with telehealth reimbursed at the same rate as a doctor’s office visit could save the Medicare program an estimated $45/visit.
Employer ROI

The Alliance conducted actuarial analysis using data from five providers:

- Teladoc
- Doctor on Demand
- Optum
- Anthem
- American Well

Table 3: Telehealth Diagnosis

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Percentage (Mean)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sinusitis</td>
<td>20%</td>
</tr>
<tr>
<td>Cold/flu/pertussis</td>
<td>12%</td>
</tr>
<tr>
<td>Bladder infection/urinary tract infection</td>
<td>6%</td>
</tr>
<tr>
<td>Respiratory condition</td>
<td>5%</td>
</tr>
<tr>
<td>Eye infection/pink eye/sty</td>
<td>3%</td>
</tr>
<tr>
<td>Skin inflammation/rash/shingles</td>
<td>3%</td>
</tr>
</tbody>
</table>
## Employer ROI

### Table 4: Distribution of Redirected Care

<table>
<thead>
<tr>
<th>Alternative Site of Care</th>
<th>Average</th>
<th>Standard Deviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room</td>
<td>5.6%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Urgent care</td>
<td>45.8%</td>
<td>11.7%</td>
</tr>
<tr>
<td>Physician office visit</td>
<td>30.9%</td>
<td>9.0%</td>
</tr>
<tr>
<td>Other clinics</td>
<td>5.4%</td>
<td>0.7%</td>
</tr>
<tr>
<td>Do nothing</td>
<td>12.3%</td>
<td>3.7%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>
# Employer ROI

Table 6: Estimated Costs – Best Estimate

<table>
<thead>
<tr>
<th>Alternative Site of Care</th>
<th>Utilization</th>
<th>Commercial ($USD)</th>
<th>Medicare ($USD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency room</td>
<td>5.6%</td>
<td>$1,595</td>
<td>$943</td>
</tr>
<tr>
<td>Urgent care</td>
<td>45.8%</td>
<td>116</td>
<td>98</td>
</tr>
<tr>
<td>Physician office visit</td>
<td>30.9%</td>
<td>98</td>
<td>83</td>
</tr>
<tr>
<td>Other clinics</td>
<td>5.4%</td>
<td>57</td>
<td>83</td>
</tr>
<tr>
<td>Do nothing</td>
<td>12.3%</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Average cost</td>
<td>100.0%</td>
<td>$176</td>
<td>$128</td>
</tr>
</tbody>
</table>
Examples of Evidence

**Journal of Telemedicine and Ehealth (2014)**
- Improved care and lower costs for CHF, Stroke and COPD.

**Health Affairs (2014)**
- Analysis Of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider (Rand Study)

**Health Affairs (2014)**
- HealthPartners' Online Clinic for Simple Conditions delivers savings of $88 per -episode and high patient approval

**Journal of Telemedicine and Ehealth (2015)**
- Showed telemedicine use for diabetes to be an "effective mode" of care, increases patient adherence and reduced cardiovascular risk factors.
Legal and Regulatory Barriers

Limited Reimbursement in Public Programs

- Medicare reimbursement is very restrictive by statute.
- Many state Medicaid programs pay for telehealth but replicate the restrictions in Medicare.

Licensure

- State-by-state licensure is cumbersome and does not lend itself to telehealth.
- Patients are portable, physician licenses are not.

Definition

- There are seven different definitions of telehealth at the federal level and dozens at the state level.
- There needs to be a consistent, technology-neutral definition of telehealth.

State Medical Boards

- As telehealth becomes more popular, state licensing boards are increasing restrictions.
- Physicians worry about patient market share going to other physicians across state lines through telehealth. They are motivated.
Federal-level Issues

• Definitions

• Section 1834(m) of Social Security Act limits telehealth reimbursement to rural areas, and can only be conducted from approved “originating sites” to “distant sites” with a physician present

• Originating site construct is very limiting

• CMS approves code modifiers for telehealth services every year, but the services are always subject to the statutory restrictions
New Reimbursement Structure

- Conventional wisdom is a move from FFS to value-based models will give patients more access to connected care.
- Currently the majority of Medicare beneficiaries are still receiving care in FFS.
- A bridge transitioning providers out of FFS is needed.
Medicare Access & CHIP Reauthorization Act

- Small statutory base rate update, if any
- Opportunity to earn bonus payments by participating in either the Merit-Based Incentive Program (MIPS) or the Alternative Payment Model (APM) track
- Risk of penalty for MIPS eligible providers who do not meet performance thresholds

### Performance Based Bonus through MIPs or APM

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Rate Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan-June 2015</td>
<td>0.0%</td>
</tr>
<tr>
<td>July-Dec 2015</td>
<td>0.5%</td>
</tr>
<tr>
<td>2016-2019</td>
<td>0.5%</td>
</tr>
<tr>
<td>2020-2025</td>
<td>0.0%</td>
</tr>
<tr>
<td>2026-Beyond</td>
<td>0.75% for qualifying APM participants 0.25% for all others</td>
</tr>
</tbody>
</table>

### Performance Based Penalty through MIPS
Merit-based Incentive Payment System (MIPS) Basics

- **What**: A “voluntary” program linking Medicare payment to performance. Providers will be judged (and paid) based on –
  - **Performance in four categories**
    - Quality
    - Resource Use
    - Clinical Practice Improvement Activities
    - Meaningful Use of Certified EHR Technology

- **Who**: Phased approach capturing additional Medicare professionals over time.
  - **2019-2020**: MDs, DOs, PAs, NPs, CNSs, CRNAs
  - **2021-Beyond**: Other eligible professionals as outlined by HHS Secretary

- **When**: Starts January 1, 2019
# MIPS Scoring

<table>
<thead>
<tr>
<th>Component</th>
<th>Weights*</th>
<th>Special Considerations</th>
</tr>
</thead>
</table>
| Quality                                        | 30%      | 2019 – Could be weighted as much as +50%  
2020 – Could be weighted as much as +45%                                                             |
| Resource Use                                   | 30%      | In 2019 and 2020, resource use shall be weighted at no more than 10 and 15%, respectively.                                                                |
| Clinical Practice Improvement Activities        | 15%      | Telehealth & Remote Monitoring Included                                                                                                                  |
| Meaningful Use of Certified EHR Technology     | 25%      | If the proportion of EPs who are MUers is equal to or more than 75%, may reduce this component, but not below 15%. If reduced, Secretary may plus up other components. |

*Secretary has flexibility to assign different scoring weights if “there are not sufficient measures and activities applicable and available to each type of EP*
Spotlight: Clinical Improvement Activity

**Clinical Practice Improvement Activities**

- **Expand practice access**
  - Expanded hours or after-hours access to clinician advice

- **Population health management**
  - Participation in clinical data registries

- **Care coordination**
  - Timely exchange of info.; telehealth and RPM

- **Beneficiary engagement**
  - Care plans for complex patients; Shared decision making tools
Spotlight: Quality Component

- CMS to publish a final list of quality measures no later than November 1st of each year, starting 2018.

- Priority shall be given to measures in the following domains –

  - Outcomes
  - Patient Experience
  - Care Coordination
  - Appropriate Use of Services
Financial Structures of MIPS

- Providers meeting or exceeding threshold receive + or neutral update
- From 2019-2024, providers in the top ¼ may receive an additional bonus payment
- Capped at $500 M annually, and no more than 10% per provider
- Providers in the bottom ¼ receive penalties:
  - 2019 – 4%
  - 2020 – 5%
  - 2021 – 7%
  - 2022 and on – 9%
Alternative Payment Model (APM) Bonus Payment Basics

• **What:** Advanced 5% bonus payment track for certain providers participating in qualifying alternative payment models

• **Who:** Providers with a significant amount of payments derived from services provided through an APM
  - “Alternative payment models” must –
    • Require quality measure reporting
    • Utilize certified EHR technology; and
    • Bear more than “nominal” risk

• **When:** Starting on January 1, 2019; running through 2024
Proposed Policies

- Increasing telehealth for MA
  - Permit MA plans to include certain telehealth services in the annual bid amount. The working group has not identified which particular services should be permitted.
- Waiving geographic location requirements for Accountable Care Organizations (ACOs) for Medicare Shared Savings Program ACOs in two-sided risk models.
- Remote patient monitoring in ACOs
  - Would allow MSSP ACOs to provide remote patient monitoring for services where Medicare fee-for-service does not reimburse.
- Telehealth for stroke and ERSD services

Next Steps

- Currently drafting final legislation expected to be released in March
CONNECT for Health Act

Background
- Introduced by Sens. Schatz (D-HI) / Wicker (R-MS) and Reps. Black (R-TN) and Welch (D-VT)
- Has received support from over 50 provider, payer, patient and vendor organizations

Provisions
- Removes geographic and payment restrictions for telehealth and RPM in Medicare
- Creates a Medicare demonstration, expiring after 2019, expanding providers use of telehealth and RPM services in anticipation of MACRA requirements.
- Provides payments to APMs for RPM services
- Expands the use of RPM for patients with 2 or more chronic conditions, and 2 or more hospitalizations in the past 12 months
- Allows MA plans to include telehealth and RPM as a basic benefit

Cost Estimate
- According to an independent analysis from Avalere Health, the Act will decrease federal spending by $1.8 billion over the next ten-year period.
- In addition, the study estimates an immediate impact improving patient access with nearly 8.2 million Medicare beneficiaries receiving telemedicine and remote patient monitoring services through a demonstration waiver program by 2017.
Congressional Advisory Groups

Congressional Budget Office
- In 2001, CBO estimated it would cost CMS $150 million during the first 5 years, or $30 million a year to reimburse for telehealth encounters.
- According to data released by CTel, since 2001, CMS’s Medicare reimbursement for distant site services totals $38.6 million and $5 million for originating site fees, for a total of $43.7 million TOTAL over 13 years.
- July 2015, CBO blog post focused specifically on telemedicine:
  - “Considerable uncertainty surrounds estimates of utilization rates”
  - Concluded lacking enough Medicare data to study potential effects of expanding coverage.

Medicare Payment Advisory Commission
- In November 2015, MedPAC began discussing the role of telehealth payments in Medicare FFS, MA, and alternative payment models
- Several commissioners agreed MedPAC needs to find a way to reduce restrictions around home health services.
- Currently MedPAC is not at the point to issue formal recommendations on telehealth expansion under Medicare.
- Initial discussion indicated a very positive outlook from the majority of the commissioners regarding the potential to increase access, especially in risk-arrangement models.
State Landscape

2016 State Legislative sessions will continue to be active

- In 2015, 200 bills across 42 state legislative bodies were introduced
- Other than pure-play telehealth companies, companies are not investing heavily in state-based advocacy and without the credible, resourced counterbalance, state medical boards will likely be successful in their bids to increase restrictions through tighter standards of care.

- Medicaid reimbursement
  - 49 states reimburse for telehealth
  - 9 states reimburse for store and forward
  - 17 states reimburse for remote patient monitoring.

- The Federation of State Medical Boards has developed a “Compact” that will hopefully expedite state licenses. Physicians will still need to be licensed in every state in which they practice, but the Compact may increase the speed of the licensure process for all states that pass the Compact.
  - Currently agreed in 11 states (AL, ID, IL, IA, MN, MT, NV, SD, UT, WV, WY)
  - In December, Wisconsin Governor Scott Walker signed legislation to join the compact
National Association of Insurance Commissions (NAIC) Network Adequacy

- **NAIC Health Benefit Plan Model Legislation**
  - In October, the NAIC released an updated iteration of the Network Adequacy model bill.
    - The draft calls for states to use “telemedicine” or “telehealth” as delivery system options when determining network sufficiency.
    - Also recommends state insurance regulators should include telemedicine and other connected care technology into the state action plans.
    - Includes “pharmacy” into “health care provider” or “provider definition.”
  - On November 22, during the NAIC Fall 2015 meeting, the model bill was unanimously accepted by the Executive Committee which paves the way for states governments to adopt the NAICs suggestions.

- **Impact**
  - The update serves as a model law for state lawmakers and HHS implementation of marketplace standards in 2017.
Value of Health STEPS

Telemedicine and remote patient monitoring have demonstrated integral roles in several STEPS™ value categories:

- **Satisfaction**
  - Telehealth services provide a convenience and access that greatly improves care and patient satisfaction.

- **Patient Engagement and Population Health Management**
  - With the payment transition to MACRA, connected care technologies will be a critical tool for engaging patients and managing populations in value-based payment models

- **Savings**
  - According to an independent analysis from Avalere Health, the CONNECT for Health Act will decrease federal spending by $1.8 billion over the next ten-year period
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