Medicare Reimbursement and Connected Health: Where Are We?

Session #169, February 13, 2019

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Conflict of Interest

Brian Scarpelli, Senior Global Policy Counsel of ACT | The App Association’s Connected Health Initiative, has no real or apparent conflicts of interest to report.
Agenda

• About the Connected Health Initiative (CHI)
• Physician Fee Schedule (PFS)
• Quality Payment Program (QPP)
• Home Health Prospective Payment System (HHPPS)
• Discussion/Questions
Learning Objectives

• Identify the discrete ways in which the use of connected health tech improves patient outcomes while reducing costs

• Explain the state of play regarding reimbursement for use of connected health tools in Medicare and understand its impact on the broader healthcare ecosystem

• Identify challenges and opportunities to the uptake of connected health tools in Medicare

• Explain how these challenges and opportunities to the uptake of connected health tools affect your organization and what actions you can take accordingly
About CHI

• The CHI is a not-for-profit multistakeholder consensus advocacy effort to advance uptake of digital health tools widely

• Intersection of medical/health industry and technology innovators

• Advocate before Capitol Hill, US agencies, European Commission, etc.

• Active in key private-sector initiatives (AMA Digital Medicine Payment Advisory Group, Xcertia, etc).
About CHI
Growing Needs (and Costs)

• 133 million+ Americans suffer from chronic conditions such as diabetes, chronic obstructive pulmonary disease, and mental illness (~171 million by 2030)

• U.S. healthcare spending to reach 20% of the entire U.S. economy 2025
Growing Needs (and Costs)

Figure 2: U.S. National Health Expenditures as a Share of GDP, 1960-2021

Source: Centers for Medicare and Medicaid Services.
Connected Health Tech in 21st Century Healthcare Systems

• Strong (and growing) body of evidence shows that connected health tech [see https://bit.ly/2MblRou]:
  – Improves patient care
  – Reduces hospitalizations
  – Helps avoid complications
  – Improves patient engagement
  – Reduces healthcare costs
• Driving Internet of Things marketplace (valued at over $250b in the U.S. alone)
• Job creation
Medicare Reimbursement – Background and Status Quo

• “Telehealth” vs. “Store-and-forward”

• 1834(m) & the historical treatment of “Medicare Telehealth Services”
  – Telehealth Services List

• Historical treatment of remote monitoring
  – Remote monitoring is not telehealth subject to 1834(m) restrictions

• Legislative efforts to address:
  – CONNECT for Health Act
  – Bipartisan Budget Act (Medicare Telestroke, ESRD, MA, ACOs) [PASSED]
  – SUPPORT for Patient and Communities Act
CY2019 PFS & Digital Health

- HCPCS code G2012 – Brief communication technology-based service (e.g. virtual check-in).
- CPT codes 99453, 99454, and 99457 – Chronic care remote physiologic monitoring.
- CPT codes 99446, 99447, 99449, 99451, 99452 – Interprofessional internet consultation.
- Updates to Medicare Telehealth Services List
CY2019 PFS: HCPCS G2012

• “Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.”
CY2019 PFS: HCPCS G2012

- Performed by a physician or other qualified health care professional who can report E/M services
  - Must be established patient
  - Allows:
    - Audio-only real-time telephone interactions
    - Two-way audio interactions enhanced with video or other kinds of data transmission
  - Not originating from a related E/M service provided within previous 7 days
  - Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment
  - 5-10 minutes of medical discussion
  - No frequency limitations
- Work RVU of 0.25, based on a direct crosswalk to CPT code 99441
CY2019 PFS: HCPCS G2010

• “Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment”
Remote evaluation of pre-recorded patient information

- Information = recorded video and/or images submitted by patient
  - Used to determine if a visit or service is needed
- Must be established patient
- Not originating from a related E/M service provided within previous 7 days
- Not leading to an E/M service or procedure within the next 24 hours or soonest available appointment
- Includes interpretation with follow-up within 24 business hours
  - Via phone call, audio/video communication, secure text message, email, or patient portal communication

Valuation as proposed with an WRVU of 0.18
• Remote monitoring of physiologic parameter(s) (e.g. Weight, blood pressure, pulse oximetry, respiratory flow rate)
  – CPT 99453 - Initial; set-up and patient education on use of equipment
  – CPT 99454 - initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
  – CPT 99457 - treatment management services (WRVU of 0.61)
    • 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month

• CMS will provide additional guidance regarding what types of technology are covered under these codes
CY2019 PFS: CPT 99453, 99454, and 99457
# CY2019 PFS: CPT 99453, 99454, and 99457

<table>
<thead>
<tr>
<th>Payment Code</th>
<th>Description</th>
<th>Payment $ (est)</th>
<th>Effective Date</th>
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<tbody>
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<td>99091</td>
<td>Collection, interpretation of physiologic data, 30 minutes or more per month by physician or other qualified healthcare professional (QHP) (professional component)</td>
<td>$59</td>
<td>Jan 1, 2018</td>
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<tr>
<td>99453</td>
<td>Initial set-up of technology and patient education (technical component)</td>
<td>$21</td>
<td>Jan 1, 2019</td>
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<tr>
<td>99454</td>
<td>Device supply with daily recordings, programmed alerts transmission, monthly (technical component)</td>
<td>$69</td>
<td>Jan 1, 2019</td>
</tr>
<tr>
<td>99457</td>
<td>Collection, interpretation of physiologic data, 20 minutes or more per month requiring interactive communication with patient by physician, QHPs, and other clinical staff (professional component)</td>
<td>$54</td>
<td>Jan 1, 2019</td>
</tr>
</tbody>
</table>
CY2019 PFS: CPT 99446, 99447, 99449, 99451, 99452

- Interprofessional internet consultation (telephone/internet assessment and management service)
  - CPT 99446 - 5-10 minutes of medical consultative discussion and review (WRVU 0.35)
  - CPT 99447 - 11-20 minutes of medical consultative discussion and review (WRVU 0.70)
  - CPT 99448 - 21-30 minutes of medical consultative discussion and review (WRVU 1.05)
  - CPT 99449 - 31 minutes or more of medical consultative discussion and review (WRVU 1.40)
- Includes a verbal and written report to the patient's treating/requesting physician or other qualified health care professional
- Billing limited to practitioners that can independently bill Medicare for E/M services
CY2019 PFS: CPT 99446, 99447, 99449, 99451, 99452

• Interprofessional internet consultation (telephone/internet/electronic health record)
  – CPT 99451 - Assessment and management service provided by a consultative physician (WRVU 0.70)
    • 5 or more minutes of medical consultative time
  – CPT 99452 - Referral service(s) provided by a treating/requesting physician or qualified health care professional (WRVU 0.70)
    • 30 minutes

• Includes a verbal and written report to the patient's treating/requesting physician or other qualified health care professional

• Billing limited to practitioners that can independently bill Medicare for E/M services
CY2019 PFS: Medicare Telehealth Services List

• Medicare Telehealth Services list:
  – Diagnosis, treatment, or evaluation of acute strokes
  – Treatment of substance abuse or co-occurring mental health disorders
  – Clinical assessment for monthly end state renal disease (ESRD)
CY2019 PFS: Acute Stroke Treatment

• Removes originating site restrictions
  – Services may be furnished in any hospital, critical access hospital, or mobile stroke unit, or any other site determined appropriate by HHS
  – Mobile stroke unit provides services to diagnose, evaluate, and/or treat acute stroke symptoms
CY2019 PFS: Substance Abuse Treatment

• Removes geographic requirements for telehealth services furnished on or after 7/1/2019
  – Individual’s home now a permissible originating site
    • No originating site fee required in this case
• Practitioner responsible for diagnosis and determining whether telehealth treatment is clinically appropriate
• CMS will provide additional subregulatory guidance
CY2019 PFS: ESRD

• Removes geographic requirements
  – Individual’s home now a permissible originating site
• ESRD patients receiving home dialysis may choose to receive monthly telehealth clinical assessments on or after 1/1/2019
  – Must receive a non-telehealth face-to-face visit on a monthly basis during first three months of home dialysis and at least once every 3 consecutive months thereafter
Quality Payment Program

• Until 2015, payment increases for Medicare services were set by the Sustainable Growth Rate (SGR) law which capped spending increases according to the growth in the Medicare population. SGR had to be passed by Congress annually.

• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed SGR and created the Quality Payment Program (QPP) to “reward high value, high quality Medicare clinicians with payment increases - while at the same time reducing payments to those clinicians who aren’t meeting performance standards.”
Quality Payment Program

- Clinicians have two tracks to choose from in the Quality Payment Program based on their practice size, specialty, location, or patient population:
  - Merit-based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models

- QPP started on January 1, 2017.
- More information: https://qpp.cms.gov/
Quality Payment Program

Merit-based Incentive Payment System (MIPS)

• Performance measured through the data clinicians report:
  – Quality
  – Improvement Activities
  – Promoting Interoperability (formerly Advancing Care Information)

• MIPS designed to update and consolidate previous programs, including: Medicare Electronic Health Records (EHR) Incentive Program for Eligible Clinicians, Physician Quality Reporting System (PQRS), and the Value-Based Payment Modifier (VBM).
Quality Payment Program

• Improvement Activities (IA) notables:
  – “Engage Patients and Families (using PGHD) to Guide Improvement in the System of Care” is classified as a "high-weighted" activity
  – “Use of CEHRT to Capture Patient Reported Outcomes” remains a "medium-weighted" activity

• Advancing Care Information (ACI) Performance Category
  – 10% Bonus for using CEHRT to complete at least one IA
Quality Payment Program

- **Activity ID, Title:** IA_BE_14, Engage Patients and Families to Guide Improvement in the System of Care
- **Subcategory:** Beneficiary Engagement
- **Weighting:** High
- **Eligibility for Advancing Care Information Bonus:** Yes

**Full Activity Description:** Engage patients and families to guide improvement in the system of care by leveraging digital tools for ongoing guidance and assessments outside the encounter, including the collection and use of patient data for return-to-work and patient quality of life improvement. Platforms and devices that collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient, including patient reported outcomes (PROs). Examples include patient engagement and outcomes tracking platforms, cellular or web-enabled bi-directional systems, and other devices that transmit clinically valid objective and subjective data back to care teams. Because many consumer-grade devices capture PGHD (for example, wellness devices), platforms or devices eligible for this improvement activity must be, at a minimum, endorsed and offered clinically by care teams to patients to automatically send ongoing guidance (one way). Platforms and devices that additionally collect PGHD must do so with an active feedback loop, either providing PGHD in real or near-real time to the care team, or generating clinically endorsed real or near-real time automated feedback to the patient (e.g. automated patient-facing instructions based on glucometer readings). Therefore, unlike passive platforms or devices that may collect but do not transmit PGHD in real or near-real time to clinical care teams, active devices and platforms can inform the patient or the clinical care team in a timely manner of important parameters regarding a patient’s status, adherence, comprehension, and indicators of clinical concern.
Quality Payment Program

• An Alternative Payment Model (APM) is a payment approach that gives added incentive payments to provide high-quality and cost-efficient care
  – Approved by both the Physician-Focused Payment Model Technical Advisory Committee (PTAC) & HHS.
  – APMs can apply to a specific clinical condition, a care episode, or a population.

• Remaining challenges:
  – Rule text on Alternative Payment Models (APMs) still omits discussion of telehealth/remote monitoring
  – Lack of development of QPP APMs through PTAC & HHS
Home Health Prospective Payment System & RPM

- Home health agencies (HHAs) are public, nonprofit or proprietary agencies that provide skilled nursing services and at least one of the following other therapeutic services: physical therapy, speech language pathology, or occupational therapy, medical social services, or home health aide services in a place of residence used as a patient’s home.

- The HHPPS provides HHAs with payment under a retrospective reimbursement system for all Medicare-covered home health services furnished under a plan of care (POC) paid on a reasonable cost basis.

- In 2016, about 3.4 million Medicare beneficiaries received care, and the program spent about $18.1 billion on home health care services.
HHPPS rule CMS has amended 42 CFR 409.46 (HHA allowable administrative costs) to include the costs of remote patient monitoring as an allowable HHA operating expense if remote patient monitoring is used by the HHA to augment the care planning process.

§409.46 Allowable administrative costs.

(e) Remote patient monitoring. Remote patient monitoring is defined as the collection of physiologic data (for example, ECG, blood pressure, or glucose monitoring) digitally stored and transmitted by the patient or caregiver or both to the home health agency. If remote patient monitoring is used by the home health agency to augment the care planning process, the costs of the equipment, set-up, and service related to this system are allowable only as administrative costs. Visits to a beneficiary's home for the sole purpose of supplying, connecting, or training the patient on the remote patient monitoring equipment, without the provision of a skilled service are not separately bill.
2020 and beyond
Questions

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