Telehealth Reimbursement – The Times They Are a Changin’!

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Conflict of Interest

Kim Swafford, MHA
Has no real or apparent conflicts of interest to report.

Tim Wright, MBA
Salary from InTouch Health
Agenda

• Changing telehealth reimbursement policy landscape
  – Federal legislative and regulatory activities
  – Medicare Fee-for-Service
  – Value-based payment models
• Providence St. Joseph Health Telehealth Overview
  – Reimbursement examples
• Discussion
Learning Objectives

• Explain the changing reimbursement landscape for telehealth

• Assess recent additions to telehealth reimbursement laws to capture the government’s increasing acceptance and support of telehealth

• Demonstrate, through key findings of a national survey, how healthcare providers are currently addressing telehealth reimbursement in order to provide evidence of how the changing legislation is affecting how providers utilize telehealth

• Identify how to take advantage of the policy changes to maximize billing/revenue opportunities
Payment varies by payer and state

**Medicare**
- Section 1834(m) in the Social Security Act (1997) limits telehealth payment to:
  - Rural areas
  - Approved originating sites
  - Eligible distant site providers
  - Real-time video
  - Certain services (98 codes 2019)
- Pays professional fee and facility fee

**Medicaid**
- States determine respective policies
- 50+ sets of rules

**Commercial Insurance / Managed Care**
- Varies by plan and state laws
- Telehealth “parity” laws

Historical rules for telehealth reimbursement

Medicare Limited to Designated Rural Sites

- <1% of inpatient stays
- 1.4% of outpatient stays
2018 – A pivotal year for telehealth reimbursement

Federal legislation including telehealth

<table>
<thead>
<tr>
<th>Year</th>
<th>Federal Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011-2012</td>
<td>40</td>
</tr>
<tr>
<td>2013-2014</td>
<td>80</td>
</tr>
<tr>
<td>2015-2016</td>
<td>120</td>
</tr>
<tr>
<td>2017-2018</td>
<td>160</td>
</tr>
</tbody>
</table>

+48%

Statewide telehealth legislation

<table>
<thead>
<tr>
<th>Year</th>
<th>Statewide Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>10</td>
</tr>
<tr>
<td>2017</td>
<td>20</td>
</tr>
<tr>
<td>2018</td>
<td>30</td>
</tr>
</tbody>
</table>

+5%

Source: www.congress.gov

Most states have a parity law

Source: www.cchpca.org
Several groundbreaking federal telehealth bills passed in 2018

**Bipartisan Budget Act of 2018**

<table>
<thead>
<tr>
<th>Effective January 1, 2019</th>
<th>Effective July 1, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telestroke</strong></td>
<td><strong>End-stage renal disease / home dialysis</strong></td>
</tr>
<tr>
<td>• Enables nationwide reimbursement</td>
<td></td>
</tr>
<tr>
<td>• Pays facility fee rural hospitals, CAHs</td>
<td></td>
</tr>
<tr>
<td>• Adds mobile stroke units</td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Advantage Plans</strong></td>
<td><strong>Accountable Care Organizations</strong></td>
</tr>
<tr>
<td>• Allows flexibility to add telehealth services to “core benefits” versus supplemental</td>
<td></td>
</tr>
<tr>
<td>• Pays facility fee except for home</td>
<td></td>
</tr>
<tr>
<td>• Providers can give technology to patients</td>
<td></td>
</tr>
<tr>
<td>• Allows flexibility to use telehealth in non-rural areas and home</td>
<td></td>
</tr>
</tbody>
</table>

Source: www.congress.gov
Other federal telehealth legislation that passed

<table>
<thead>
<tr>
<th>VETS Act</th>
<th>SUPPORT for Patients and Communities Act</th>
<th>Agriculture Improvement Act of 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effective June 12, 2018</strong></td>
<td><strong>Effective July 1, 2019</strong></td>
<td><strong>Reauthorized 2019-2023</strong></td>
</tr>
<tr>
<td>• Veteran services provided by VA licensed clinicians across state lines</td>
<td>• Enables nationwide payment for telemental health / substance use disorder treatments</td>
<td>• Establishes major funding increase for telehealth grants</td>
</tr>
<tr>
<td>• Telehealth visits “from anywhere to anywhere”</td>
<td>• Allows care in home setting</td>
<td>• Expands broadband</td>
</tr>
<tr>
<td></td>
<td>• Requires DEA to implement special telemedicine license by October 2019</td>
<td></td>
</tr>
</tbody>
</table>

Source: www.congress.gov
CMS creates payment for new virtual care services

<table>
<thead>
<tr>
<th>Brief Communication Technology-based Services</th>
<th>Remote Evaluation of Recorded Video and/or Images</th>
<th>Interprofessional Consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Real-time virtual check-in</td>
<td>Store and forward visit</td>
<td>Provider-to-provider consult</td>
</tr>
<tr>
<td>• HCPCS G2012</td>
<td>• HCPCS G2010</td>
<td>• CPT codes 99446 – 99449, 99451-99452</td>
</tr>
<tr>
<td>• Brief, 5-10 minutes</td>
<td>• Patient-initiated</td>
<td>• Telephone/Internet/EHR consults</td>
</tr>
<tr>
<td>• Patient-initiated</td>
<td>• Established patients</td>
<td>• Patient not present</td>
</tr>
<tr>
<td>established patients</td>
<td>• Patient consent</td>
<td>• Patient consent</td>
</tr>
<tr>
<td>• Telephone, video or other kinds of data</td>
<td>• Pays ~$13/visit</td>
<td>• Pays ~$18-$73</td>
</tr>
<tr>
<td>transmission</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pays ~$15/visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: CMS Final Rules 2019 Physician Fee Schedule
CMS expands payment for RPM

- Allows payment for professional and technical components of RPM
  - Example first month: $58 (or $52) + $19 + $64 = $141
  - Monthly thereafter: $58 + $64 = $122
- Allows billing RPM and CCM (e.g. CPT 99457 & CPT 99490) professional components for same patient, same month
- Not subject to 1834(m) telehealth restrictions

<table>
<thead>
<tr>
<th>Payment Code</th>
<th>Description</th>
<th>Payment</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>99091</td>
<td>Collection, interpretation of physiologic data, 30 minutes or more per 30-day period by physician or other qualified healthcare professional (QHP) (professional component)</td>
<td>$58</td>
<td>2018</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>$52</td>
<td>2019</td>
</tr>
<tr>
<td>99453</td>
<td>Initial set-up of technology and patient education (technical component)</td>
<td>$19</td>
<td>2019</td>
</tr>
<tr>
<td>99454</td>
<td>Device supply with daily recordings, programmed alerts transmission, monthly (technical component)</td>
<td>$64</td>
<td>2019</td>
</tr>
</tbody>
</table>

Source: CMS Final Rules 2019 Physician Fee Schedule
Implications for future reimbursement policy changes

• Turning point for FFS
• New reimbursement paradigm for 2019
  - Creates incentives to adopt telehealth
  - Drives new use cases
  - Improves economic and business models
• Trends to continue
• Catalyst for change among other payers

Near Term Telehealth Payment Opportunities

| CMS FFS | • Stroke, home dialysis, telebehavioral health / substance use disorders
| | • Brief virtual check-in, store-and-forward visit, provider-to-provider visit
| | • Remote patient monitoring
| | • Potential new areas: maternal fetal medicine, skilled nursing, genetic counseling, respiratory therapy, ED
| | • Targeted ‘Medicaid populations’
| CMS Value-based | • Medicare Advantage plans
| | • ACOs
| | • Payment bundles
Providence St. Joseph Health Telehealth Initiatives
Providence St. Joseph Health

51 Hospitals
829 Clinics
90 Non-acute services
14 Supportive housing programs

111k Caregivers
38k Nurses
20k Physicians
High school, nursing schools, and university

2 Health plans
1.9M Covered lives
$1.6B Community benefit
Footprint spans across 7 states
PSJH Overview

+118 Live sites
11 Thrombectomy centers
34,000+ Encounters in 2018
30 min T-Psych average response time for pre-consult
12% tPA rate
2m:02s T-Stroke average provider response time

3 Core Services (Behavioral Health, Neurology, Acute Care)
50 Regional Programs (7 States)
Telehealth Roadmap

How do we get there?
TeleStroke Annual Volumes & Growth

- **2016**: 1395
- **2017**: 3210 (130% growth, 62/wk avg, 9/day avg)
- **2018**: 5165 (Over 45% growth, 90/wk avg)
Evolving Telestroke Value Proposition

• Continued emphasis on “door to needle time” & keeping care close to home

• HOWEVER, reimbursement paradigm is shifting…new FAST Act will require Medicare to reimburse for pro fees regardless of where the patient is located
EXAMPLE | Impact of physician payment

2018
Currently the number of urban encounters for telestroke is approximately 60% of our cases, no reimbursement for those cases

2019
By end of 2019 approximately 1000 video encounters per year = ~$150K in professional fees annually
Remote Patient Monitoring (RPM)

• Care for our Communities & Innovate with the Times

• Improve Patient Outcomes | Decrease Readmissions | Increase Engagement

• Affordable, Reliable, Easy-to-Use
  – Develop a holistic and multidisciplinary approach
  – Engagement with Telehealth, Regional Clinical Leaders, Heart Institute, Home Health, and Nursing

• Align strategic vision and care plans throughout
  – Standardized Workflows, KPI’s, Tracking Mechanisms
RPM Expansion | KPIs

**Key Performance Indicators**

- Reduce unnecessary 30-day readmissions for CHF & COPD by 30%
- Decrease Length of Stay by 50% for CHF program
- Improve Patient Engagement and Satisfaction
  - Increase provider and staff satisfaction
  - Increase patient adherence

**Clinical Service Offerings**

- Remote monitoring and engagement with patient for adherence to care plan
- Remote monitoring of patients' vitals
- Escalation support for elevated vitals

**Staffing Models Options**

- Local nursing monitoring of patients' vitals
- Outsourced remote monitoring of patients' vitals
- Critical: Physician endorsement and support of RPM program

**Platform**

- Platform requirements include ease of use, multiple disease management options
- Back-end data and analytics
- Streamlined back-end dashboard for daily clinical review

**Financial Implications**

- Opportunities to decrease cost by preventing low acuity readmissions
- Decrease low acuity chronic disease LOS
- Reimbursement for RPM chart review
EXAMPLE | RPM Financial & Reimbursement Opportunity

Average Direct Variable Expense Saved: ~$9,000
- For avoidable readmission
- Mean per-patient CHF related hospitalization is ~$14,500

Average Cost/RPM Kit: ~$135/patient/month
- Average patient enrolled in program: 90 days

Provider Reimbursement $60/month
- Requirement: 30 minute patient chart review
- Involved ECG, blood pressure, and glucose monitoring

Can be billed along side:
- Chronic Care Management CPT Codes- $47/patient/month
- Transition Care Management CPT Codes - based on local physician fee schedule
Questions

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