2020 NRTRC TAO VIRTUAL CONFERENCE

Northwest Regional Telehealth Resource Center and the Telehealth Alliance of Oregon

Welcome You

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Pacific Northwest University of Health Sciences

University of Utah Health Clinical Neuroscience

VIRTUAL SESSION INSTRUCTIONS

- Audio and video are muted for all participants
- Use the Q&A feature to ask questions 
- Moderator will read questions to the speaker
- Presentation slides are posted at https://nrtrc.org/sessions. Recordings will be posted after the conference.

Telehealth 101 Workshop

- Moderator: Deb LaMarche
- Presenters:
  - Cindy Roleff, Telehealth Program Development Manager, Alaska Native Tribal Health Consortium
  - Cara Towle, Associate Director, Psychiatry Consultation & Telepsychiatry, University of Washington
  - Cathy Britain, Executive Director, Telehealth Alliance of Oregon
  - Deb LaMarche, Program Director & Principal Investigator, Northwest Regional Telehealth Resource Center
  - Jennifer Erickson, Acting Assistant Professor, University of Washington
  - Tammy Arndt, Director, Northwest Telehealth

GETTING PAID FOR TELEHEALTH

Creating Financial Stability

for Telehealth services

Creating a Sustainable Business Model

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- Telehealth is a BUSINESS!
- Begin with good data – know your market
- Who else is in the market, and how are you going to distinguish your program from others?
- Create well-defined metrics that will allow you to measure your success, AND make adjustments for the future
- Grants are short term “seed capital” not a long term revenue source!
- Reimbursement is only a part of a good telehealth business model

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Telehealth Payment Models: Fee for Service

- Definition: Fee-for-service - a system of payment in which a doctor or other health care provider is paid a fee for each particular service rendered.
  - The traditional model of payment
  - Must meet structured requirements for payment
- Contractual agreements – a provider contracts with a healthcare entity to provide a service to that entity often on a monthly basis
  - Example – company provides tele-hospitalist services to a hospital for a fixed amount each month

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Telehealth Payment Models: Fee for Service

- Membership 1 – Healthcare entities purchase a membership in a network. One or more of the entities provides services needed by the others.
- Membership2 – A patient can purchase a membership for services offered by a health entity.
  - Example – an urgent care center offers memberships for individuals or families for a flat fee for a specific number of visits per month/year
- Direct access – a patient schedules an appointment with a provider as needed.

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Telehealth Payment Models: Managed Care

- Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

Telehealth Payment Models: Value-based Care

- Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.
- Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The “value” in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.

According to the Center for Telehealth and eHealth Law (CTEL)

- *The absence of consistent, comprehensive reimbursement policies is often cited as one of the most serious obstacles to total integration of telehealth into health care practice. The lack of an overall telehealth reimbursement policy reflects the multiplicity of payment sources and policies within the current United States health care system.*

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Who Pays for Telehealth?

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- Medicare (including Medicare Advantage Plans)
- Medicaid (Managed care organizations, fee for service)
- Private Payers
- ERISA (self-insured company plans)
- Patient self pay

Medicare

- Medicare beneficiaries are eligible for telehealth services if:
  - They are presented in an originating site located in a CMS defined rural area.
- In addition:
  - The type of originating site must be approved by CMS;
  - The type of provider must be approved by CMS; and
  - The type of service must be approved by CMS
  - The services must be provided using two-way audio and video telecommunications that are HIPAA compliant

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Medicare Expansion

- Beginning in 2019 CMS made some major changes to the services it will reimburse when delivered via telehealth:
  - Expansion of originating site
    - Renal Dialysis Facilities*
    - Homes of beneficiaries with ESRD receiving home dialysis*
    - Mobile Stroke Unit *
    - Beneficiaries home when receiving SUD and related mental health services*
  - ***Geographic limitations do not apply***

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Medicare - COVID rules

- Medicare will pay for services delivered to their beneficiaries in any health care facility and in their homes. These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
- Medicare has expanded the list of eligible services. (Easy to use list: https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf)
- Medicare has added FQHCs and RHCs to the list of eligible providers for the emergency period only
- Medicare will allow any mobile computing device that have audio and video capabilities to be used in the provision of services. The HHS Office of Civil Rights may waive penalties for HIPAA violation
- Medicare will not enforce the established relationship requirement

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Medicare – COVID rules

- A subsequent inpatient visit can be furnished via telehealth without the limitation that the telehealth visit is once every three days (CPT codes 99231-99233);
- A subsequent skilled nursing facility visit can be furnished via telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)

Medicare Facility Fee – Originating Site

- Originating national sites allowed $26.65

  Per Medicare Economic Index (MEI) defined by Social Security Act annually

- Submit Q3014 without modifiers
- Submit appropriate place of service (POS)

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Medicare Facility Fee - COVID rules

- The originating site facility fee cannot be paid to the home.

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Medicare Other Technology - Enabled Services

- **Per CMS: Innately not face-to-face = not "telehealth"**
- During COVID clinicians, including physicians, can now provide certain services by telephone to their patients (CPT codes 98966 -98968; 99441-99443)
- Virtual Check-Ins (HCPCS G2012)
  - Established patients
  - No E/M in prior 7 days or subsequent 24 hours/"soonest available"
  - 5-10 minutes of discussion
  - During COVID clinicians can provide services to both new and established patients.

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Medicare Other Technology - Enabled Services

- E-Visits - Remote Evaluation of Pre-Recorded Data (HCPCS G2010)
  - Established patient sends recorded images or videos through a patient portal
  - Interpretation and follow-up in 24 hours
  - No E/M in prior 7 days or subsequent 24 hours/ “soonest available”
  - During COVID consults may be providedto a patient beyond the once per day limitation (CPT codes G0508-G0509).
  - During COVID licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech language pathologists can provide e-visits. (HCPCS codes G2061-G2063).

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Medicare Other Technology - Enabled Services

- Interprofessional Consultations (eConsults)
  - 6 codes - 5 for consultative physician; 1 for treating or requesting physician or QHP (99446, 99447, 99448, 99449, 99451, 99452
  - Telephone, internet, EHR assessment/management
  - Verbal and/or written reports required
  - Certain limitations on frequency

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Remote Patient Monitoring

- Codes Effective January 1, 2019
  - Education/Equipment Set – Up (CPT 99453)
  - Device Supply (CPT 99454)
  - Collection and interpretation of data (CPT 99457)
  - 99457 – calendar month
  - Accounts for equipment related costs
  - No face to face exam
  - 20 minutes
  - Clinical staff allowed

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Remote Patient Monitoring

- Certain detailed requirements
  - Minimum of 16 days
  - Consent
  - Co-pay applies
- During COVID clinicians can provide services to both new and established patients
- During COVID these services can be provided for both acute and chronic conditions and can now be provided for patients with only one disease.

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Remote Patient Monitoring

- As of November 2019, RPM services reported with CPT codes 99457 and 99458 may now be furnished under general supervision. The physician or other qualified healthcare professional supervising the auxiliary personnel doesn’t require both parties to be in the same building and can be accomplished through telemedicine.
- CPT code 99457 only covers the *initial* 20 minutes of monitoring services, while CPT code 99458 is used as an add-on code for those patients who receive additional 20 minutes intervals of RPM.

Medicaid

- Medicaid patients are eligible for telehealth services based on the policies of the state in which they reside.
- The policies are those determined by CMS or by the terms of their 1135 waiver
- Information on Medicaid reimbursement policies prior to COVID for individual states can be found at the Center for Connected Health Policy web site: https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies
- The changes made to state laws to better manage COVID can be found at: https://www.cchpca.org/resources/covid-19-related-state-actions

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Private Payers

- Reimbursement from private payers is also dependent on the laws and policies of each state.
- Private payer reimbursement can extend beyond what is in policy or legislation depending on what the payer sees as a valuable service and what the payer and provider are able to negotiate into the contract.
- Private payer legislation/ policy for each state can be found on the CCHP web site at: https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies?jurisdiction=All&category=128&topic=All

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ERISA – Self Insured Company Plans

- Many employers fund group health plans for their employees.
- Those plans are regulated by the Employee Retirement Income Security Act (ERISA).
- The plans must be in compliance with state laws. Most parallel laws governing private payers
- Although ERISA does not have a policy on telemedicine, they recognize the value telemedicine can provide to both employers and employees.
- ERISA works with states to encourage the development of telehealth and not impose barriers to its use.

Patient Self Pay

- Patients can choose to pay for a service delivered telemedically themselves if their insurer denies payment
- This occurs especially when the services are direct-to-patient such as virtual urgent care.
- People without insurance and seniors with Medicare are often willing to self-pay in order to get the services they need/want
- Payers are seeing positive data generated by these services and some are offering their own products

Reimbursement Soup

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How to manage the chaos

- Early in your planning determine the problem you are trying to solve with telehealth and what populations you want to serve
- Familiarize yourself with the laws governing payment for these services and for each population being served
- Develop a relationship with the payers involved. Find a point of contact within each organization who knows and understands their policy on telemedicine
- In the case of Medicaid, private payers and ERISA payers, work with your contracts office to negotiate the most favorable contract for the services you want to provide
- Join or develop a group of providers to gather information and develop strategies for dealing with these payers in your state.

Keep in Mind

- Telehealth reimbursement during COVID does not look like it did prior to the pandemic, and it will not necessarily look the same after the pandemic ends.
- Many are hoping that the laws will remain as they are now, but a solid business plan is not built on what we hope will happen.
- Telehealth providers have the remarkable opportunity to show that telehealth can function better in this relaxed regulatory environment by keeping good data for our services during this time.

Never hesitate to ask for help!

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Resources

- https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
- https://edit.cms.gov/files/document/medicare-telehealth-frequently-asked-questions-faqs-31720.pdf
- https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- https://www.cms.gov/files/document/covid-19-physicians-and-practitioners.pdf

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Resources

- For Medicaid:
  - https://www.cchpca.org/telehealth-policy/state-telehealth-laws-and-reimbursement-policies-report
  - https://www.cchpca.org/telehealth-policy/current-state-laws-and-reimbursement-policies for COVID
  - Check with the state's health authority Medicaid offices for up-to-date resources on telehealth reimbursement

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Resources

- For Private Payers and ERISA:
  - Check with the state Health Authority and/or Department of Consumer and Business Affairs and/or Department of Insurance for information

- For General Resources:
  - https://nrtrc.org/covid-19
  - https://www.cchpca.org/

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Thank you!

- Contact information
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  - www.ortelehealth.org

What we must decide is how we are valuable rather than how valuable we are.
~Edgar Freidenberg

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