Telehealth: Overcoming the challenges of implementing innovative health care solutions

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Roki Chauhan, MD, FAAFP
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Learning Objectives

- What are some of the challenges for providers who want to introduce telehealth into their practice?
- What are some of the challenges for commercial health plans/insurers to implement telehealth programs/initiatives?
- How do we overcome these potential barriers?
Background Information
Healthcare delivery and reimbursement is undergoing significant change

- Provider organizations are in the midst of redesigning how they see and treat patients
- Commercial health plans and Medicare are changing their reimbursement from fee-for-service to models based on value
- Sophisticated healthcare technology is enabling rapid change
- Patients are becoming more active consumers

The transition is difficult and disruptive for all
As cost share increases, patients forego care*

*Source: PwC 2015 Health and Well-being Touchstone survey, Gallup Poll, and PwC HRI consumer surveys
Cost-shifting pushes consumers to make different choices about their healthcare

Percentage of consumers with employer-based insurance who took the following actions in the last 12 months due to cost of care

- **28%** Skipped seeing a doctor
- **28%** Asked for a generic prescription instead of a brand prescription
- **24%** Skipped prescription medicine or took less medication than prescribed
- **20%** Skipped seeing a specialist (such as an OB/GYN, dermatologist, orthopedic surgeon)
- **18%** Skipped follow-up care (such as going to physical therapy sessions recommended by a doctor)
- **16%** Delayed or skipped a procedure or treatment

Source: PwC Health Research Institute 2015 consumer survey
Patients are becoming more active consumers...and are seeking more affordable options

Source: PwC Health Research Institute 2015 consumer survey
The future is here…

“You can’t list your iPhone as your primary-care physician.”
Telehealth
Telehealth: On the forefront of new ways that people seek and receive care

- 30% of patients use computers or mobile devices to check medical or diagnostic information
- 74% of consumers would use telehealth services if given the opportunity
- 76% of patients prioritize access to care over the need for human interactions with healthcare providers
- 70% of patients are comfortable communicating with their healthcare providers via text, e-mail, or video, in lieu of seeing them in person

Source: Telemedicine and Employers: The New frontier - Epstein Becker Green, February 2015
http://www.lexology.com/library/detail.aspx?g=ee9fc27d-d56c-4fc8-9b17-42b381db495a
Prediction: In 5 – 7 years, telehealth will be part of mainstream medicine

- Improves access to care
- Offers lower-cost alternatives
- Improves communications between patients and doctors
- Reduces unnecessary care
- Enables better management of care, esp. chronic care
- States are passing regulations for Medicaid and commercial payors to cover telemedicine visits

Washington state’s telehealth law was enacted in 2015 and provides coverage for all essential health benefits offered by private insurance, state employee health plans and Medicaid managed care by 2017
Example: Teleradiology

- Initial concerns about quality or off-shoring
- Now has become a fairly standard practice
- The American Telemedicine Association announced at the 2015 Fall Forum that 7.5 million Americans have their images read by a teleradiologist each year
Provider Challenges
Provider challenges

- Work flow - how does a provider incorporate telemedicine into his or her practice?
  - Solo or small practices
  - Large practices
  - Health care systems
  - Single-specialty versus multispecialty

- Electronic Medical Records
  - Can data and information be incorporated into an EMR?
  - Can data and information be readily shared between different systems? Different EMRs?

- Other practice settings
  - Home visits
  - Retail clinics
  - Pharmacies
Provider challenges (continued)

- **Health plans**
  - How does provider work with different health plans who may have chosen different telemedicine vendors or have different coverage rules in the same market?

- **Competition**
  - How does a provider compete with well-funded organizations that offer these services - provider group has to decide if it will in-source or out-source?

- **Communication**
  - How can the technology be leveraged to improve the doctor-patient relationship?

- **Consolidation**
  - How does provider consolidation enable or hinder the use of telehealth in a practice?

- **Reimbursement**
  - Will new reimbursement models encourage providers to incorporate telehealth into their practices?
Overcoming provider challenges

- **Primary care**
  - Telemedicine visits could make up 25% of a provider’s practice day
  - Telemedicine is ideal for chronic disease and certain acute illnesses

- **Behavioral Health**
  - Improves access to care
  - Convenience
  - Removes potential stigma of seeing a mental health specialist

- **Put yourself into the mindset of the physician**
  - Providers are busy – they are trying to get through their day
  - How does telehealth make life better for them and their patients?
A PORTRAIT OF TODAY'S DOCTOR

Based on a Survey of America's Physicians in 2014: Practice Patterns and Perspectives
Responses from over 20,000 Physicians

81% Workload at capacity or overextended
19.5 Average patients seen per day
85% Have implemented electronic medical records (EMR)
53% Are employed by hospital or group

49% Patients covered by Medicare/Medicaid
53 Average hours per week
33% Participate in State/Federal exchanges
35% Are in private practice

26% Participate in Accountable Care Organizations (ACOs)
17% Are in solo practice

20% Of day spent on paperwork or other non-clinical duties
50% In groups of 11 or more
20%

Source: http://www.merritthawkins.com/compensation-surveys.aspx - see infographic
Example: Decrease in ER use and inpatient days with the use of virtual care for patients with diabetes

<table>
<thead>
<tr>
<th></th>
<th>Base Case (No Virtual)</th>
<th>Virtual Care</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Utilization per 100,000 individuals</td>
<td>Costs per 100,000 individuals ($ Millions)</td>
<td>Utilization per 100,000 individuals</td>
</tr>
<tr>
<td>Hospital inpatient days</td>
<td>193,011</td>
<td>$622 M</td>
<td>173,710</td>
</tr>
<tr>
<td>Physician office visits</td>
<td>792,697</td>
<td>$158 M</td>
<td>673,792</td>
</tr>
<tr>
<td>Virtual visits</td>
<td>-</td>
<td>-</td>
<td>294,035</td>
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<tr>
<td>ER visits</td>
<td>69,256</td>
<td>$71 M</td>
<td>62,330</td>
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<tr>
<td>Hospital outpatient visits</td>
<td>79,160</td>
<td>$57 M</td>
<td>75,584</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>$908 M</td>
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Source: PwC Health Research Institute analysis
Physician compensation

- Providers are primarily paid based on productivity
- Medicare is shifting from “pay for volume” to “pay for value”
- Commercial health plans are also implementing a variety of pay for value models
- Providers in large organized practices are already seeing a shift in their reimbursement model, for example:
  - 80% productivity
  - 20% quality/outcomes/patient experience
Medicare: Sifting to “Pay for value”

- 30% of Medicare payments tied to quality in 2016
- 50% by 2018
- Two options for providers:
  - Merit-Based Incentive Payment System (MIPS)
  - Alternative Payment Model
MIPS: Most physicians will choose this option

- MIPS replaces existing quality reporting programs in Medicare Part B
- Score based on four categories:
  - Quality
  - Resource Use
  - Clinical practice improvements
  - EHR meaningful use
- Physicians will be assessed, and receive payment adjustments based on a composite score (1 to 100)
- Resource use may increase to 30% in 2021
## Commercial health plans: Value-based payment

<table>
<thead>
<tr>
<th>Payment Models (examples)</th>
<th>Description</th>
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<tbody>
<tr>
<td>Enhanced Fee-For-Service</td>
<td>Increase in FFS payment for Patient Centered Medical Homes</td>
</tr>
<tr>
<td>Quality-based Incentives</td>
<td>Increase in payment based on quality measures, utilization and patient experience</td>
</tr>
<tr>
<td>Shared Savings</td>
<td>Practices rewarded with portion of savings if the total cost of care is lower than trend or quality thresholds are met</td>
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<tr>
<td>Partial or Global Risk</td>
<td>Partial or complete risk based on metrics related to total cost of care</td>
</tr>
<tr>
<td>Bundled Payment</td>
<td>Primarily for surgical procedures such as total hip and total knee surgery</td>
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As providers take on more risk, they will be looking at new ways to deliver high quality care efficiently.
Providers are looking for solutions to improve quality and efficiency

- If you target providers for your products or services:
  - Demonstrate how you will help them meet or exceed CMS and commercial health plan requirements for value-based reimbursement
  - Demonstrate how you will help them improve the patient experience
  - Convince physician practices to invest the resources on remote patient monitoring based on improvement in chronic disease management and decrease in hospitalizations or ER use
Health Plan Challenges
Health plan challenges

- Health plan challenges for telemedicine fall into multiple categories
  - Medical Loss Ratio
  - Vendors
  - Providers
  - Members
  - Blue Plans versus National Plans
  - Competing priorities
  - Resources
Health Plan Challenge: MLR

- Under ACA requirements, commercial insurers must ensure that 80% of premium goes to health care costs or quality improvement for individual and small groups (85% for large group).
- If they do not hit those thresholds, then they must reimburse enrollees with a rebate the following year.
- Demonstrate that what you offer contributes to the numerator as defined by ACA and NAIC in order for a health plan to consider your telehealth offering.

Source: Kaiser Family Foundation

\[
\begin{align*}
\text{ACA MLR} &= \frac{\text{Health Care Claims} + \text{Quality Improvement Expenses}}{\text{Premiums} - \text{Taxes, Licensing & Regulatory Fees}} \\
\end{align*}
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Health Plan Challenges: Vendors

- How does a health plan deal with multiple vendors of telehealth with different financial models?
- Should a health plan contract directly with a telemedicine vendor or does the health plan remain agnostic to the vendor and have the vendor contract with providers?
- How does a regional health plan in one state offer telemedicine for its members/enrollees in another state?
- What is the impact of the vendor service on the MLR calculation?
- How does a health plan ensure quality of care for these services?
Health Plan Challenges: Providers

- How does health plan measure and ensure quality of care and appropriate utilization?

- What if a provider in health plan’s network does not offer telemedicine?
  - E.g., someone’s PCP does not offer telemedicine but the patient wants a web visit?

- Is provider reimbursement paid at fee-for-service rate or is it incorporated into a value-based payment model?

For commercial payors, provider reimbursement is in transition from FFS to Value-Based Payments
Health Plan Challenges: Members

- Telemedicine
  - Members expect coverage for web-visits
  - Health plans are implementing coverage rules
- Remote patient monitoring
  - Currently most commercial health plans do not cover RPM
  - Rationale - need sufficient evidence in peer-reviewed medical literature
  - Challenge - administrative expense rather than medical claim, therefore does not help MLR calculations
Blue Cross Blue Shield Plans versus National Plans

- How does a BCBS health plan in one state offer telemedicine for its members/enrollees in another state?
  - BCBS plans can only contract with the providers in their service area
  - Some BCBS plans will therefore have to offer two options:
    - Network providers offer telemedicine within their region
    - National vendor solution as a “wrap around” for their out-of-area members
  - Will national vendor provide timely information back to PCP?

- What happens if a state has more than one BCBS plan who choose different vendor solutions?
  - Potential confusion in the market
Overcoming obstacles
“Cycling Worlds”

- All organizations, including providers and health plans, are constantly shifting between “two worlds”
- Need to find out where they are at any given moment in time and then demonstrate that what you offer will help them
Questions?

Roki Chauhan, MD, FAAFP
Chauhan Healthcare Consulting, LLC
rokichauhan@gmail.com