National Rural Health Association Policy Brief

2017 Telehealth Policy for the National Rural Health Association

Introduction

Telemedicine has been around for decades, but is just now really becoming mainstream with the congruence of technology, lower costs, electronic medical records, and healthcare reform. Regulatory proceedings cannot keep up with the speed in which technology changes. Many of the goals of various healthcare reforms over the past 5-10 years have been to streamline healthcare processes and procedures, and reduce the growing cost of healthcare delivery in the United States (US). Telemedicine has the potential to incorporate technology into the equation for delivering access to a greater number of people at a lower per capita cost.

Rural residents in our country remain poorer, sicker, and have lower life expectancies than their urban counterparts. (National Advisory Committee, 2015) The prevalence of Medicare and Medicaid patients is much higher in rural areas. Telemedicine can overcome many barriers related to healthcare access in these rural areas. However, several regulatory barriers must be overcome. The goal of this policy paper is to demonstrate how telemedicine can assist safety net healthcare providers in caring for the residents in the rural and underserved areas in which they live and work.

Recommendations

- Remove geographic inequities that require patients to be in a HPSA or non-MSA
- Remove separate billing and coding inequities for telemedicine services
- Expand the list of eligible providers to include allied health professionals
- Expand eligible originating sites to include a patient's home
- Provide reimbursement for store and forward applications
- Allow Federally Qualified Health Centers and Rural Health Clinics to act as both the originating and distant site

Background

While many may believe that telemedicine is a relatively new delivery methodology for healthcare, the truth is that its root are much longer, deeper, and more convoluted than one may realize. In fact, the ancient Greeks can be credited with same of the earliest communications over

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long distances. (Bashshur, 2009) Dr. Jay Sanders is often referred to as the "Father of Telemedicine" in the United States. He began a long distance video program in the late 1960's during his residency with Massachusetts General Hospital in Boston. Dr. Sanders is a founding board member of the American Telemedicine Association (American Telemedicine Association, n.d.) in addition, has served on numerous boards and committees including the NASA Biological and Physical Research Advisory Committee. (Sanders)

In the United States, Medicare began reimbursing physicians for telemedicine services in the late 1990s. Each year, Medicare adds new CPT codes for telemedicine reimbursement. As of October 2017, forty-eight states and the District of Columbia offer some type of telemedicine reimbursement in their state Medicaid programs. (Center for Connected Health Policy, 2017). Over time, many commercial and private payers have also started reimbursing for telemedicine services. Most commercial insurance reimbursement varies by state and follows any parity legislation for the state. Parity legislation increase the incentive for health care providers to utilize innovative telemedicine technologies like Chronic Care Management and Remote Patient Monitoring to reduce the prevalence of access to health care. (Yang, 2016)   United Healthcare is unique in that they have publically posted their national telemedicine policy. (United Healthcare Community Plan, 2017)

In the last ten years, new technologies have had a significant effect the way the public lives their lives. According to Pew Research Center, as of November 2016, 95% of Americans own a cell phone. Of those, 77% are smart phones. (Pew Research Center, 2017) Consumers are becoming more reliant on their smart phones and tablets. As the cost and availability of consumer healthcare activity trackers, fitness applications, and Bluetooth enabled devices expand, so does the appetite of the consumer for instant gratification. Their desire for healthcare services has likewise expanded with the advent of Electronic Medical Records, Healthcare Portals, and movements like Meaningful Use in the healthcare industry. Technology savvy individuals now want to receive healthcare services directly from electronic devices, just like they order household goods from Amazon.com.

Many studies and clinical trials have been conducted around the cost effectiveness of telemedicine and the consensus seems to be that telemedicine can be a cost effective approach. According to the American Hospital Association, in 2012, patients participating in their telemedicine program constituted a savings of $6500 per patient compared to patients who did not participate in telemedicine. The cost of treating a patient for telemedicine was approximately $1600 per year vs $13,000 a year for traditional homebased care provided by the VA. It also reduced hospital admissions by 19% and a 25% reduction in bed days. (American Hospital Association, 2016) With rural Americans having less access to healthcare, less access to reliable transportation, greater distances to travel to receive the care and lower income than their urban counterparts the benefits of telemedicine should be able to provide Medicare and Medicaid recipients a similar benefit as it did to the VA.

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The National Quality Forum conducted a valuable report regarding the efficacy of telemedicine. (National Quality Forum, 2017) They found that telehealth, by overcoming geographical distances; can build efficiencies into the healthcare delivery system. The committee measured various methods of telehealth. The report serves to further research in telehealth methodologies by serving as a foundation for quality measurement. They determined that telehealth activities would be especially useful in rural and underserved areas where patients have more risk factors and tend to be older.

Types of telemedicine programs
Similar to the myriad of telemedicine technology companies, the number of unique telemedicine services is also expansive. Following are four main categories most programs fall under:

- Primary Care
    - Direct-to-consumer programs fall into this category. Any time a patient is seen through the use of synchronous audio and video technology by a primary care provider who is at a distance from the patient.
- Specialty Care
    - Prominent examples of this are telestroke, teleneurology, and tele-trauma. Rural hospitals often contract with specialty providers to treat patients as quickly as possible without transporting the patient long distances.
- Integrated Behavioral Health
    - This category encompasses everything from emergency psychological examinations for a patient who presents in an Emergency Department (ED) without a full-time psychologist to outreach programs for Post-Traumatic Stress Disorder.
- School Based Programs
    - This type of program allows school aged children to be seen by a physician, nurse practitioner, or physician assistant during the school day, without leaving the school grounds. This eliminates the need for the parent to leave work (and possibly have decreased wages) in order to take their child to the doctor. In instances where the child does not have a primary care physician, this would eliminate improper use of the local ED or minute clinic. School based programs have become so popular that there is now an organization dedicated to providing support for these types of programs: School Based Health Alliance: http://www.sbh4all.org/tag/telemedicine/
- Project ECHO
    - Project ECHO started at the University of New Mexico and has expanded all over the country. It is a hub-and-spoke model for specialists to share their knowledge and expertise. https://echo.unm.edu/

Issues

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Financial viability of telemedicine programs is often limited by reimbursement. (Arndt, 2017) In many rural communities served by Rural Health Clinics, Community Health Centers and Rural Hospitals, the payer mixes are predominately Medicare or Medicaid. According to the 2010 Census, 23% of Medicare beneficiaries live in rural America. (Rural Health Information Hub, 2014) For non-elderly in rural areas, 24% rely on Medicaid for their health coverage. (Foutz, 2017) Added to that, the major reimbursement challenges inhibiting wider implementation of telemedicine throughout the United States are ironically also Medicare and Medicaid, who also have the most restrictive payment methods for telemedicine services.

Medicare telemedicine reimbursement is limited by (Center for Medicare and Medicaid Services, 2018):
- Geographic restrictions (originating site must be outside of a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA) located in a rural census tract
- Provider eligibility (only physicians, nurse practitioners, physician assistants, nurse-midwives, clinical nurse specialists, certified registered nurse anesthetists, clinical psychologists, clinical social workers, and registered dieticians or nutrition professionals
- Coding (less than 100 eligible PCHPCS/CPT codes)
- Ineligibility of store and forward sites (only available in demonstration projects in Hawaii and Alaska)

Restrictions for Rural Health Clinics is further limited by (Center for Medicare and Medicaid Services, 2018)
- Originating site only – RHCs are only authorized to serve as originating sites for telehealth services, and may not serve as distant sites for telehealth services.

Restrictions for Federally Qualified Health Centers is further limited by (Centers for Medicare and Medicaid Services, 2016)
- Originating site only – Federally Qualified Health Centers are only authorized to serve as originating sites for telehealth services, and may not serve as distant sites for telehealth services.

The current reimbursement policy outlined by CMS requiring the aforementioned limitations continues to restrict the access of tele-health on a broader scale. By limiting reimbursement to less than 100 CPT/HCPCS Codes and to beneficiaries in geographic locations of less than 50,000 people or less located in a HPSA, the benefits of telemedicine are very restricted.

Healthcare providers must adapt to multiple billing and coding processes. Beginning January 1, 2018, a '02' Place of Service (POS) code should be used on Medicare claims to indicate that a service 'meets telemedicine requirements'. (MLN Matters, 2017) This POS code was previously introduced in 2017, replacing the GT modifier that was previously used to indicate that a service was provided via telemedicine. However, distant site services that are billed under CAH method II billing should still use the GT modifier, and the GQ modifier to still to be used by

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demonstration projects in Alaska and Hawaii. For 2018, CMS has not adopted the 95 modifier that was adopted by the American Medical Association in 2017.

Medicaid telemedicine reimbursement varies from state to state (Center for Connected Health Policy, 2017):
- 49 states and the District of Columbia have a definition for telehealth, telemedicine, or both
- 48 states and the District of Columbia provide reimbursement for live video
- 15 states provide reimbursement for store and forward
- 21 states provide reimbursement for remote patient monitoring (RPM).
- 30 states require informed consent before payment is allowed
- 9 states issue specific licenses of certificates related to telemedicine
- 8 states have adopted the 02 POS code (as of October 2017)
- 4 states have adopted the 95 modifier (as of October 2017)
- The programs very greatly by state allowing for misunderstanding and acceptance

While Medicaid is administered on the state level by design, often times the states will follow the lead of federal precedent in health care policy. By not having a strong national standard for tele-health reimbursement, each state has devised very different rules, which creates severe limitations in some states and a broader acceptance nationally. While the elimination of the GT modifier was not a surprise to Medicaid programs, only a few adopted the 02 POS in 2017. With the 2018 elimination of the Medicare GT modifier, hopefully more Medicaid programs will change their billing processes to be consistent with the new 2018 Medicare guidelines. (CCHP, 2017)

As long as telemedicine is seen as a cost-driver to our system and remains a perceived threat by some providers as a competition to a traditional practice, it will never fully be utilized to its potential. We need to find payment models that offer ideas such as providing a capitated payment system to providers per beneficiary but gives providers leeway to use telemedicine as a tool in achieving outcomes if we want to see wider implementation nationally. We also need to address the inconsistencies state by state to develop a more uniform telemedicine system. With so much uncertainty and with the various health reform proposals being considered in Washington DC, it is hard to develop a consistent advocacy strategy until we can be more certain of the structure of our health care reimbursement policy nationally.

Has telemedicine finally found its niche? While telemedicine technologies have existed for nearly 50 years, it is only in the past five to seven years that telemedicine has really started hitting the mainstream media. The healthcare industry is in a perfect storm, with healthcare costs approaching 20% of the Gross Domestic Product (GDP). (CMS, 2017) In 2015, healthcare spending in the US was 17.8% of the GDP. During the same period, we have seen the emergence of Electronic Medical Records, Health Information Exchanges, and wearable

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healthcare tracking devices. Buzzwords in the healthcare industry range from Triple Aim to Population Health and Value-Based Purchasing. The CMS Innovation Center (CMMI) has created the Medicare Shared Savings Program (MSSP), which is a form of an Accountable Care Organizations (ACO). These and many other programs have been created to reign in the increasing cost of healthcare in the US. The use of telemedicine within these innovative programs allow health care providers to be more creative in the way they serve the needs of the individuals in their market areas

Innovative Programs with Telemedicine Components
Chronic Care Management
CMS Introduced the CPT Code 99490 in 2015. (CMS, 2017) In 2017, CMS introduced two additional CPT codes for Complex CCM; 99487 and 99489. While none of these codes is telemedicine codes, the provision of these services often includes the use of telemedicine technology. Yet many healthcare providers are still not taking advantage of these revenue streams.

MACRA, MIPS, and APM
MACRA stands for the Medicare Access & CHIP Reauthorization Act. (CMS, 2015) The MACRA program was introduced by the Department of Health and Human Services as a way to tie Medicare payments to quality and value through Alternative Payment Models (APM). The goal of the Merit-based Incentive Payment System (MIPS) is to link quality and value to fee-for-service payments. MACRA streamlines the Physician Quality Reporting Program (PQRS), Value-Based Payment Modifiers, and the Medicare EHR Incentive Program into MIPS. MIPS uses a composite performance score to adjust provider's Medicare Part B base rates by 4% (positive or negative) in 2019 and ranges up to 9% by 2022. In order the meet the quality and value goals in the different categories under MACRA, healthcare providers will need to be innovative in the way they deliver healthcare services. The incorporation of telemedicine technologies can be a tool to help achieve the overarching goals for value and quality.

Comprehensive Primary Care Plus is a unique public-private partnership (Center for Medicare and Medicaid Services, 2018) that gives practices flexibility and additional financial resources for improving the quality of care and reducing unnecessary services. This national program aimed at strengthening primary care is an advanced primary care medical home model. As of January 2018, there are nearly 3,000 primary care practices participating in the program. The program includes three payment elements: 1) Care Management Fee, Performance-Based Incentive Payments, and 3) Payment under the Medicare Physician Fee Schedule. These payment elements include risk-adjusted payments that allow for provider flexibility in treating patients via telemedicine, or by incorporating other cost effective population health programs like chronic care management and remote patient monitoring.

Next Generation Accountable Care Organizations are able to file a telemedicine waiver
(Centers for Medicare & Medicaid Services, 2017) that allows them to provide healthcare

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services to Medicare beneficiaries who are in their homes. This waiver effectively eliminates the need for the beneficiary to be physically located at an eligible originating site like a clinic or Critical Access Hospital; it also eliminates the restriction that the originating site be located outside of a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA). Extending this waiver to all ACOs would allow increased access to health care services to a larger rural population throughout the country.

Wearables and Apps

Many consumers today already use health related wearables and apps to improve their health. The number of technology vendors and solutions in this market is an ever-changing landscape. The National Telehealth Technology Assessment Resource Center (TTAC, 2013) has created toolkits for guiding healthcare providers in the decision making process when evaluating telemedicine technology devices.

Working with primary healthcare providers to track patient health data for chronic care management seems an easy next step in the evolution from fee-for-service to value-based purchasing methodologies of increasing quality measures and providing better outcomes for our patients. Technology advances have always outpaced legislation and probably always will. It is up to legislators to codify language broad enough to allow for proper patient care, while yet being flexible enough to allow technology advances to thrive.

Direct-to-Consumer

The Direct-to-Consumer telemedicine platforms that allow patients to download an application on a smart phone or tablet and access a health care provider within minutes are becoming more popular, While this market is one of the newest areas of telemedicine, is also one of the most rapidly changing types of telemedicine related services. The concept for this type of direct connection between a consumer/patient and a healthcare provider can be traced back as far as 1999 for Joseph Kvedar. (Kvedar, 2014) He recalls a speaking engagement in 1999 about "a webcam application that would allow a non-dermatologist" (like a primary care doctor) "to upload images of a patient's skin". The dermatologists in the room felt threatened and did not think such an application would ever be used. But yet, in 2014 when the article was written, Direct-to-Consumer telemedicine was starting to gain a foothold in the telemedicine arena. Many of the larger healthcare systems have collaborated with direct-to-consumer platforms in an effort to protect their market share. Even large healthcare insurers are getting in on the act. Anthem BSBC of Indiana offers LiveHealth Online to its members for free. (LiveHealth Online, 2015) . Without adequate broadband access, consumers would not be able to use these types of platforms to communicate with healthcare providers.

Federal and Healthcare Landscape Progress

Significant progress has been accomplished in reducing regulatory barriers that impede the continued development of telemedicine, however barriers still exist.

- CMS issued final regulations, on May 5, 2011, removing the regulatory burden for provider credentialing and privileging by healthcare organizations. "Privileging by

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proxy" has allowed for a significant reduction in time and cost associated with privileging multiple providers in multiple sites, thereby enhancing access and lowering the cost for telemedicine services. (Telehealth Resource Center, 2016), (Federal Register, 2011)

- Patterned after existing Nurse Licensure Compacts, the Interstate Medical Licensure Company is an agreement between 22 states and the 29 Medical and Osteopathic Boards in those states, who, as of December 2017 have created a compact that allows licensed physicians to practice medicine across state lines. (Interstate Medical Licensure Compact, 2017)

- Legislative attempts to re-define the "place of service" for telemedicine, from the originating site (site of patient), to the distant site (site of provider), holds promise, but have yet to gain the necessary support to move them forward.

Recommendations

In summary, telemedicine increases access and improves outcomes. Following are the recommendations for regarding telemedicine reimbursement:

- Remove geographic inequities that require patients to be in a HPSA or non-MSA
- Remove separate billing and coding inequities for telemedicine services
- Expand the list of eligible providers to include allied health professionals
- Expand eligible originating sites to include a patient's home
- Provide reimbursement for store and forward applications
- Allow Federally Qualified Health Centers and Rural Health Clinics to act as both the originating and distant site