TELEHEALTH PUBLIC POLICY TRENDS AND ISSUES

CTTI Mobile Clinical Trials (MCT) Legal & Regulatory Project Expert Meeting
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CENTER FOR CONNECTED HEALTH POLICY
We are part of the Public Health Institute, an independent, public interest organization dedicated to promoting better systems of care improved health outcomes & provide greater equity of health access to quality, affordable care and services for all.
HRSA/OAT GRANT 2012-2016

Telehealth technologies are valuable assets to help achieve the “Triple Aim” of improved quality of care, better health outcomes, and lowered costs.

Learn More >>

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CENTER FOR CONNECTED HEALTH POLICY
Advances in telecommunication technologies can help **redistribute health care expertise and resources** to where and when it is needed, and create greater **value** among consumers, public & private payers, and health systems.
VALUE OF TELEHEALTH

1. Timely Access to Diagnosis & Treatment

• Primary and Specialty Care Services (Live or Asynchronous Store & Forward)
• Direct to Consumer
• Acute, Chronic, & Emergency Care
...WHERE THE CONSUMER IS LOCATED
VALUE OF TELEHEALTH

2. Enhanced Consultation/Communication

- Patient/Consumer ↔ Health Care Team
  - Uses secure portal for email communication or live video using smartphone, tablet or computer.
  - Directly Connects Consumers to Care Team
PRIMARY TO SPECIALIST CONSULTATION

- **eConsult**: a web-based system that allows PCPs and specialists to securely share health information and discuss patient care
- Improves timely access to specialist while enhancing the PCP knowledge and services
- Web-based, asynchronous
3. VALUE OF TELEHEALTH

Remote Monitoring

- Management of Chronic Conditions
- In Home-Aging in Place
- Acute Intensive Care (Tele-ICU)
- Bluetooth or broadband connected
Remote Monitoring Can Improve Quality & Save Money

- **Congestive heart failure** best managed by long-term telemonitoring
- **Obstructive pulmonary disease** best treated with telepulmonology that remotely measures lung function
- **Stroke** most effectively treated via telestroke methods that prompt early tPA interventions
- A 2014 Canadian study showed **telehomecare** saved 14% ($1,613 per patient per year) over traditional care, by reducing hospitalizations by 45%, emergency department visits by 35%, and achieving 50% shorter hospital stays
Value of Telehealth: Aging in Place

• Close to Family /Social Supports Improves Well-Being
• Enhances the Care Giver Support
• Reduces Sense of Isolation-Connected to the World
4. MOBILE CONNECTED HEALTH

- Health care, public health, and health, education & personal health monitoring
- Supported by mobile phones, tablet computers, and other mobile communication devices
- Can be targeted (promoting healthy behavior and disease management) to wide-scale (disease outbreak alerts)
CMS reimbursement policy for Medicaid:

“States may reimburse for telehealth under Medicaid so as long as the service satisfies federal requirements of efficiency, economy, and quality of care.”
TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS

Laws, Regulations, Pending Bills State & Federal

Interactive Policy Map

CENTER FOR CONNECTED HEALTH POLICY
KEY POLICY AREAS OF ANALYSIS & REFORM

• **Definition:** Telemedicine or telehealth?
• **Reimbursement:** by modality (live video, Store and forward, remote patient monitoring)
• **On-line Prescribing:** In-person exam required?, who is eligible, and what type of drugs)
• **Consent:** (written, verbal, none?)
• **Cross-state licensing:** conditional practice, FSMB compact
• **Private Payer Parity:** (parity of service, payment, conditioned to terms of policies?)
• **Location of Service:** originating site requirements
• **Site Transmission Fee:** yes, no?
April 2017 Analysis & Key Findings

43 states
Have a definition for **TELEMEDICINE**

32 states & DC
definition for **TELEHEALTH**
Alabama and New Jersey have no definition

Remote Patient Monitoring
22 states

Reimbursement:
Live Video: 48 states (Rhode Island & Mass do not)

Store and Forward
Only in 13 states

Reimburse for all three: Only 5 states
Medicaid Reimbursement Trends

![Bar chart showing Medicaid Telehealth Reimbursement trends for Live Video, Store & Forward Modality, and RPM for different months, including Feb. 2013, Feb. 2014, Feb. 2015, and Mar. 2016.](chart.png)
PARITY IN PAYMENT WITH IN-PERSON

35 states and DC have active telehealth private payer laws

This is the most common policy change at the state level!

Parity is difficult to determine:
- Parity in services covered vs. parity in payment
- Many states make their telehealth private payer laws “subject to the terms and conditions of the contract”
ON-LINE PRESCRIBING

• Most states determine the use of an on-line questionnaire to establish the patient/provider relationship as inadequate for prescribing.

• Virginia, Michigan and Ohio allow for the prescribing of certain controlled substances of certain conditions are met.

• Some states leave it up to the Medical Board to establish guidelines for online prescribing.
STATE POLICY BEYOND LEGISLATION:

• **Regulatory** and administrative actions still needed to fully implement legislation

• **Courts** also play a role in interpretation of legislative policy

• Professional **licensing** boards can limit the benefits of legislation
FEDERAL: MEDICARE PROGRAM

HISTORY OF FEDERAL TELEHEALTH POLICY

Balanced Budget Act of 1997
- Medicare beneficiaries in rural HPSAs may receive care via telehealth
- Practitioner required to be w/patient during consult
- Consulting & Referring physicians share fee (75/25)

Benefits Improvement & Protection Act 2000
- Included non-MSA sites
- Eliminated fee sharing
- Expanded eligible services for reimbursement

Medicare Improvements for Patients & Providers Act, 2008
- Expanded list of facilities that may act as an originating (patient location) site

Various Changes Made Administratively
- Credentialing & Privileging Regulations
- Increase in number of codes reimbursed
- Redefinition of “rural”
- Inclusion of Chronic Care Management Codes

Medicare telehealth policy very limited & has not changed much in recent years
Medicare & Telehealth

SOCIAL SECURITY ACT OF 1835(m) or 42 USC 1395m

- Only **Live Video** reimbursed
- Store & Forward (Asynchronous) only for Alaska & Hawaii demonstration pilots
- Specific list of providers eligible for reimbursement
- Limited to rural HPSA, non-MSA, or telehealth demonstration projects
- Limited types of facilities eligible
- Limited list of reimbursable services, but CMS decides what can be delivered via telehealth and reimbursed
- **Approximately 80 codes reimbursed if provided via telehealth out of 10,000 possible codes**

Total Medicare telehealth payments in 2015: $75,460,785
Total Medicare payments 2015: $600 Billion
MOVING FROM VOLUME TO VALUE

**Volume-based**
- Pay for service (volume)
- Cost-based reimbursement
- Hospital/physician independence
- Inpatient focus
- Stand-alone care systems
- Illness care

**Value-based**
- Pay for results (quality/efficiency)
- Shared risk
- Partnerships and collaborations
- Continuum of care
- Community health improvement (HIT)
- Wellness care
Next Generation ACO- Breakthrough for Telehealth

• CMMI Demonstration Model offers financial arrangements with higher levels of risk and reward
• Greater access to home visits, telehealth services, and skilled nursing facilities;
• “benefit enhancements” allow circumvention of Medicare rules that go beyond benefits of Medicare Advantage -Alternative Payment Model
• Would allow ACOs to utilize the technology regardless of a patient’s geographic location.
THANK YOU-FOR MORE INFORMATION PLEASE VISIT OUR WEBSITE: WWW.CCHPCA.ORG