Financial Considerations for Telehealth Sustainability

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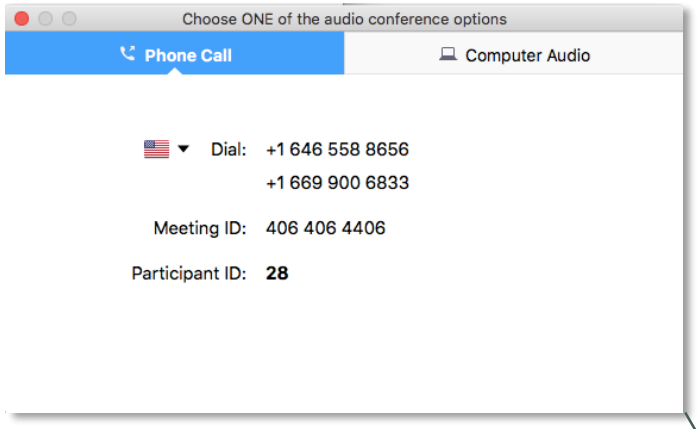
TUESDAY, MARCH 26, 2019

Zoom tips and tricks!

CHAT: Please jump in if you have something to share, but we also have this nifty chat function.

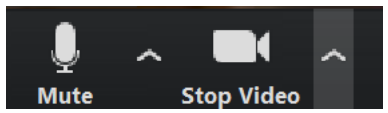
ATTENDANCE: If there are multiple attendees together on the call, please list the names and your location in the chat box

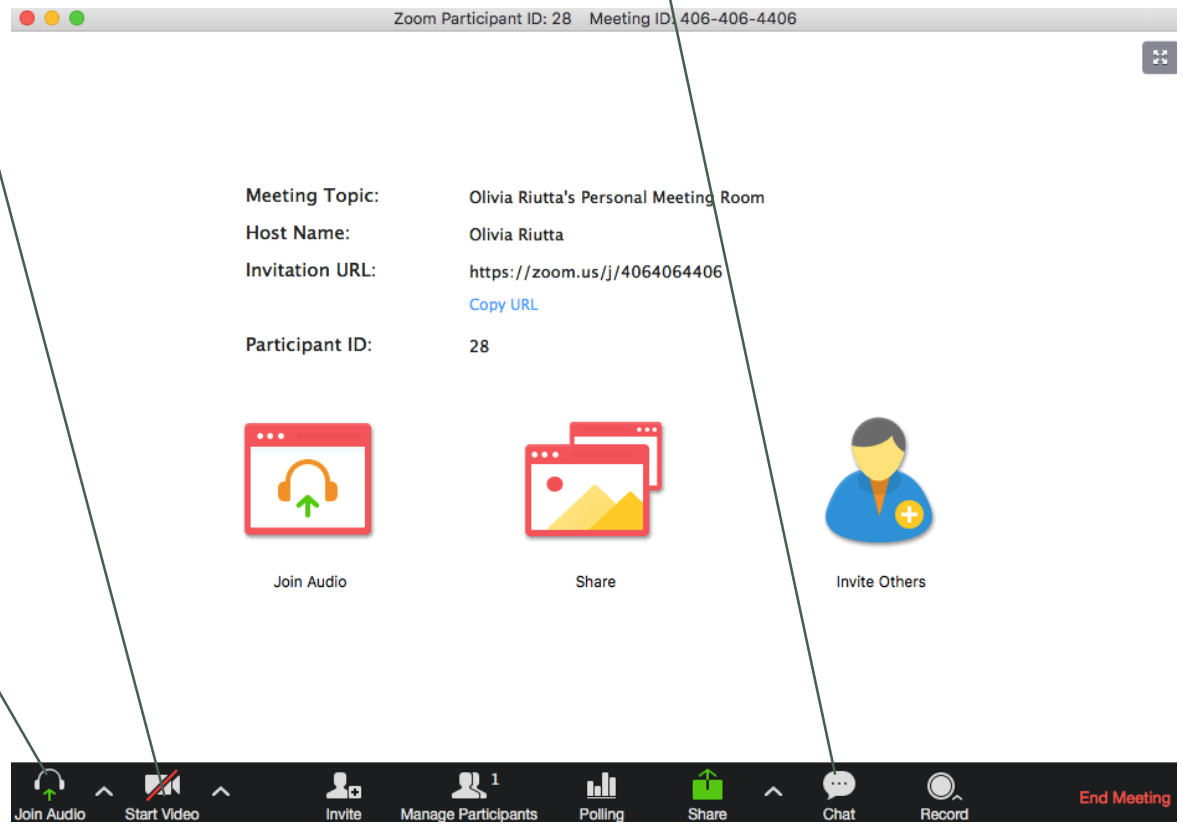
VIDEO: We want to see you!
If your camera isn't on, start your video by clicking here.



AUDIO: You can use your computer speakers or your phone for audio. The phone is generally better quality. If you click "Join Audio," this "Choose one…" box will pop up. If you dial in, just make sure you include your audio code.

MUTE/UNMUTE: *6 or click the mic on the bottom left of your screen.





Upcoming HCCN Webinars

Patient Rights, Information Blocking and HIPAA: What Healthcare Providers Need to Know

with Susan Clarke

Tuesday, March 26, 2019 at 1:00 p.m.

Are you ready for Telehealth? Assessing your Health Center for Telehealth Implementation

Tuesday, April 23rd at 11:00 a.m.

2019 Meaningful Use Promoting Interoperability Overview

Wednesday, March 27th at 11:00 a.m.

Using Virtual Health to Enhance Patient Care

Tuesday, May 28th at 11:00 a.m.

https://www.mtpca.org/news-and-events/events/

Save the Date: HIPAA/Virtual Health in Person Training

June 5-6, Helena

Agenda

- Quick Review of Telehealth Modalities
- Building a Sustainable Telehealth Program
- Reimbursement Considerations for Telehealth: Commercial, Medicaid and Medicare
- HRSA Scope of Project

Telehealth Modalities

Live Video

(aka Synchronous)

Virtual Patient Visits

Store and Forward

(aka asynchronous)

Retinal Screens, Dermatology, Radiology, Glucose Uploads

Remote Patient Monitoring

Can be Synchronous or Asynchronous

Mobile Health/mHealth

Types of Sites

- **Originating Site**: location where the patient is physically located while receiving telehealth technology

- **Distant Site:** location where the provider or consulting specialist issuing the service via telehealth technology

- **Hub and Spoke Model:** Refers to a larger hospital or specialty care group (hub) that provides care via telehealth to primary care or other sites (spokes) that lack access to those services. This model can also include a physician or practitioner located at **"distant site"** ("hub") furnishes care to a patient located at an "**originating site**" ("spoke")

Building a Sustainable Telehealth Program

- Set Organizational Objectives
  - Perform Needs Analysis
  - Determine unmet needs
    - Specialist consult
    - Visits between sites
    - Follow up with patient after hospital discharge
    - Remote patient monitoring
- Be Strategic about Technology
  - Does existing equipment/software meet your needs?
  - Being clear on objectives can help ensure you select the right technology
  - Initial Costs and ongoing maintenance
- Consider Revenue Sources
  - Understand reimbursement and challenges
  - Grant opportunities
  - Collaboration opportunities
- Use Traditional Performance Metrics
  - What do you track for in person visits?
    - Return on Investment
    - Cost Avoidance
    - Improved outcomes
- Keep it Sustainable
  - Continue evaluating reimbursement
  - Understand how telehealth will affect your cash flow

https://www.hfma.org/Content.aspx?id=42573


Reimbursement

Reimbursement Challenges

- Lack of consistent telehealth reimbursement policies between Federal, State and private payers
- Variances on types of services covered
  - Live Video
  - Store and Forward
  - Remote Patient Monitoring
  - Mobile Health/mHealth
- Medicare FQHC benefit and FQHC prospective payment system (PPS) have presented obstacles to FQHCs receiving payment under Medicare for remote or technology-based care

Montana Private Payer Reimbursement

Service Parity: Private payers are required to provide coverage for services delivered through telemedicine if the services are otherwise covered by the policy, certificate, contract, or agreement.

- Coverage must be equivalent to the coverage for services that are provided in person by a health care provider or health care facility.
- Services must be **medically necessary** as subject to terms and conditions of policy
- **Might reimburse** for live video and store-and-forward
- **State definition does not include** audio-only telephone, e-mail, or facsimile transmissions

Eligible Providers under Montana Parity

Physicians

Physician Assistants

Podiatrists

Pharmacists

Optometrists

Physical Therapists

Occupational Therapists

Speech-language Pathologists and Audiologists

Psychologists

Social Workers

Licensed Professional Counselors

Nutritionists

Addiction Counselors

Registered professional nurse

Advanced practice registered nurse

Genetic counselor certified by the American board of genetic counseling

Diabetes educator certified by the national certification board for diabetes

Dentists & Dental Hygienists

Eligible Facilities under Montana Parity

Critical access hospital

Hospice

Hospital

Long-term care facility

Mental health center

Outpatient center for primary care

Outpatient center for surgical services

Montana Medicaid Reimbursement

- **Montana Medicaid Definitions of Telemedicine**
  - Department of Public Health and Human Services: 'Telemedicine is the use of interactive audio-video equipment to link practitioners and patients located at different sites.'
  - Healthy Montana Kids: Telemedicine is "the use of a secure interactive audio and video, or other telecommunications technology by a health care provider to deliver health care services at a site other than the site where the patient is located. Does not include audio only (phone call), e-mail, and/or facsimile transmission."
- MT Medicaid reimburses for medically necessary telemedicine services to eligible members
- Healthy Montana Kids: Services provided by telemedicine are allowed for non-surgical medical services and behavioral health outpatient services.

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Montana Medicaid Continued

- **Montana Medicaid**
  - **will** reimburse for live video in some circumstances (medically necessary)
  - **will not** reimburse for store-and-forward, remote patient monitoring or for consultation by telephone
  - Telemedicine can be provided in a member's residence: distance provider responsible for confidentiality requirements
- The originating and distant providers may not be within the same facility or community or have the same tax ID number.
- FQHC's can bill as originating site or a distant site, but they can not bill both for the same encounter
- No originating site fee can be charged if the patient is being seen from their residence
- Providers must be licensed in the state of Montana

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Montana Medicaid Eligible Providers for Originating Site Fee

The following provider types can bill the originating site fee:

Outpatient hospital

Critical access hospital

Federally qualified health center

Rural health center

Indian health service

Physician

Psychiatrist

Mid-levels

Dieticians

Psychologists

Licensed clinical social worker

Licensed professional counselor

Mental health center

Chemical dependency clinic

Group/clinic

Public health clinic

Family planning clinic

Medicare Services

Three types of remote and/or communication based services under Medicare Part B:

1)**Telehealth** services are considered a substitute for an in-person visit (Social Security Act (SSA) §1834(m); 42 C.F.R. §410.78)

- Medicare only reimburses for live-video conferencing telehealth services under very specific circumstances
- Restrictions on originating site, distant site and types of services

2) **Virtual Communication** services brief discussions via remote technology with a practitioner to determine if a visit is necessary (Medicare Physician Fee Schedule (PFS) Calendar Year (CY) 2019 Final Rule)

- "Virtual check-ins"
- Remote evaluation services

3) **Care management services** that may involve the use of remote technology (42 C.F.R. §405.2464; various years' CMS PFS Final Rules)

- Transitional Care Management
- Chronic care management
- Behavioral health integration
- Psychiatric collaborative care model

Core Requirements for Medicare Telehealth Reimbursement

1) Technology : Live Video
   - “Interactive telecommunications system” –“audio and video equipment permitting two-way, real-time interactive communication between the patient and the distant site physician or practitioner”

2) Location where the patient is located (includes a health center site located in a HPSA)
   - Geographic Requirements: non-Metropolitan Statistical Area (MSA) or Rural Health Professional Shortage Area (HPSA_
     - Some exceptions for acute stroke and end stage renal disease and treating substance use disorders added in 2019
   - Originating Site Restrictions: Federally qualified health centers are applicable as originating sites

3) Eligible providers
   - Physicians, Nurse practitioners, Physician assistants, Nurse midwives, Clinical nurse specialists, Clinical psychologists and clinical social workers, Registered dieticians or nutrition professionals

4) Covered Telehealth Service
   - List of specific services/CPT codes Medicare will reimburse for via telehealth updated each year by the US Department of Health and Human Services

Medicare Telehealth Reimbursement

Two components to Medicare payment:

1) Originating Site = Facility Fee

- Located in a health professional shortage area (PHSA §332(a)(1)(A)) that is either outside a Metropolitan Statistical Area (MSA) or within a rural census tract of an MSA
- Located in a county that is not located in an MSA (as defined in SSA §1886(d)(2))
- **Note:** SUPPORT for Patients and Communities Act (Oct. 24, 2018) §2001(a) removed originating site geographic requirements for purposes of treating individuals with a substance use disorder

2) Distant Site= typically, Medicare pays the same amount that Medicare would have paid if the service had not been provided via telecommunications

- Medicare telehealth services are considered a “non FQHC/RHC service”
- FQHC may not bill for distant site telehealth service, and associated costs may not be included as FQHC service costs on the cost report
- “This includes telehealth services that are furnished by an RHC or FQHC practitioner who is employed by or under contract with the RHC or FQHC, or a non-RHC or FQHC practitioner furnishing services through a direct or indirect contract.”

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Medicare Telehealth Reimbursement Continued

- FQHCs are not authorized to serve as a distant site for telehealth consultations, and may not bill or include the cost of a visit on their cost report (CMS Manual, Pub 100-02, Chapter 13, Section 20)
- Per CMS regulation, an FQHC “visit” must be “face-to-face” (42 C.F.R. §405.2463)
- CMS has interpreted the term “face-to-face” in the regulation to mean that the FQHC visit must occur in person **(not via telehealth)**
- This “face-to-face” requirement would need to be modified in order for FQHCs to be able to bill for a telehealth visit

Medicare Virtual Communication Reimbursement

CMS Medicare Physician Fee Schedule (PFS) Calendar Year (CY) 2019 Final Rule recognized two new types of “virtual communication services”

1) **Communication technology-based services (“virtual check-ins”)**
   - real-time discussion between practitioner and patient
2) **Remote evaluation services**
   - practitioner evaluates patient-transmitted pre-recorded information (*e.g.*still or video images, information from heart rate monitors); practitioner interprets the information and follows up within 24 hours

- Changes effective 1/1/2019 will allow FQHC’s to bill for Brief Communication Technology Based Service, or a “Virtual Check-In” and Remote Evaluation Services
- The final policy aims to modernize the healthcare system and help “restore the doctor-patient relationship” by reducing administrative burden.
- Significant changes to Medicare Telehealth Services and adds new services
- The services are “not a substitute for a visit, but are instead brief discussions with the RHC or FQHC practitioner to determine if a visit is necessary”

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Medicare Virtual Communication Reimbursement Continued

Payment methodology

- FQHCs: rate based on national average non-facility PFS rate of HCPCS codes G2012 and G2010: **G0071** for 2019 is $13.69

Program requirements for virtual check-ins/ remote evaluation:

- FQHC provides at least 5 minutes of medical discussion conducted remotely
- Recipient must be ***established patient*** of FQHC (had at least one billable visit in prior year)
- Rendering clinician must be FQHC practitioner (not nurse, health educator, etc.)
- Service **must be initiated by patient**
- Discussion must be for a condition **not related to an FQHC service provided in prior 7 days,** and **it does not lead to an FQHC service within next 24 hours (or soonest available appointment)**

Medicare Virtual Communication Reimbursement Continued

Communication technology

- Virtual check-ins: audio-only telephone interactions; “two-way audio interactions that are enhanced with video or other kinds of data transmission”
- Remote evaluation services: practitioner follow-up may take place “via phone call, audio/video communication, secure text messaging, or patient portal communication”
- **Note:** no patient location requirements; no limitations on frequency

Relationship to FQHC/RHC services

- CMS considers virtual communication services to be included within “FQHC services”; nonetheless, the costs of the service are **not** included within the PPS rate
- FQHCs should list costs associated with virtual communication services in the “other than RHC/FQHC services” portion of Medicare cost report

Medicare Virtual Communication Reimbursement Continued

Billing requirements and payment

- FQHC bills for the services on FQHC (institutional) claim
- Services may be billed either on their own or on a claim with other FQHC services
- One G code (G0071) will be used to pay for both virtual check-ins and remote evaluation services
- Payment rate for G0071 set at national average of the non-facility PFS payment amounts for G2012 and G2010 (in CY2019, **$13.69**).
- There is no bar on an FQHC billing Medicare for virtual communication services in the same month as it bills Medicare for care management services for the same patient.

Medicare Virtual Communication Reimbursement Continued

FQHCs must impose coinsurance for virtual communication services

- Coinsurance is equal to 20% of the lesser of the fee schedule amount or the health center's designated charge
- FQHCs should ensure that their charge master includes a charge for these G codes
- Collection of coinsurance may be more challenging given that the service does not involve a face-to-face visit

FQHC must obtain beneficiary consent for virtual communication services are furnished

- Consent must be obtained in advance of furnishing service
- Consent may be verbal or written
- Must be documented by treating practitioner in patient's medical record

Medicare Care Management Services

Beginning in **CY2019**, CMS has added a new CPT code to the bundle of codes for which Medicare pays for care management; corresponds to 30 minutes or more of CCM furnished by a physician or other qualified professional

- FQHCs bill for the services on an FQHC claim: General Care Management Code G0511
  - Transitional Care Management (TCM)
  - Chronic care management (CCM)
  - Behavioral health integration (BHI)
  - Psychiatric collaborative care management (CoCM)
- CCM may be furnished to patients with multiple chronic conditions that are expected to last at least 12 months and that place the patient at significant risk of death or functional decline
- Separately billable initiating visit with FQHC/RHC practitioner required

Medicare Care Management Services

- No requirement that CCM be furnished by physician or practitioner; services may be rendered by auxiliary personnel
- As with virtual communication, care management services are considered under the regulations to be part of the FQHC/RHC benefit, but paid for separate from the PPS [42 C.F.R. §405.2464(c)]
- Associated costs are reported in the “Other than RHC/FQHC services” field of cost report
- Patient consent is required and patient co-insurance applies

Reimbursement Wrap Up

- Understanding the variances of reimbursement between Federal, State and private payers can be helpful in determining which services you offer
- Incremental changes in reimbursement will continue to take place as further legislation develops
- Think outside of the box: Are there collaboration opportunities or grant funding opportunities available?
- Consider approaching telehealth incrementally/start slow or have a pilot program: keep an eye on guidelines and review reimbursements as received
- Do some of the benefits to your patients outweigh the reimbursement challenges?
  - Improved outcomes
  - Increased access to care
  - Etc.

HRSA Scope of Project

- Service: Is the telehealth service provided directly, by contract, or by referral
- Site: Consider how to record the provision of services via telemedicine in the scope of project
  - Where is the patient located?
  - Where is the provider located?
  - Are both locations reflected in the Forms 5B (or 5C, as applicable)?
- Consider whether HRSA prior approval is required
- If you are unsure regarding whether/how to record a particular location in scope, write your Project Officer and save the correspondence

Wrap Up and Questions?

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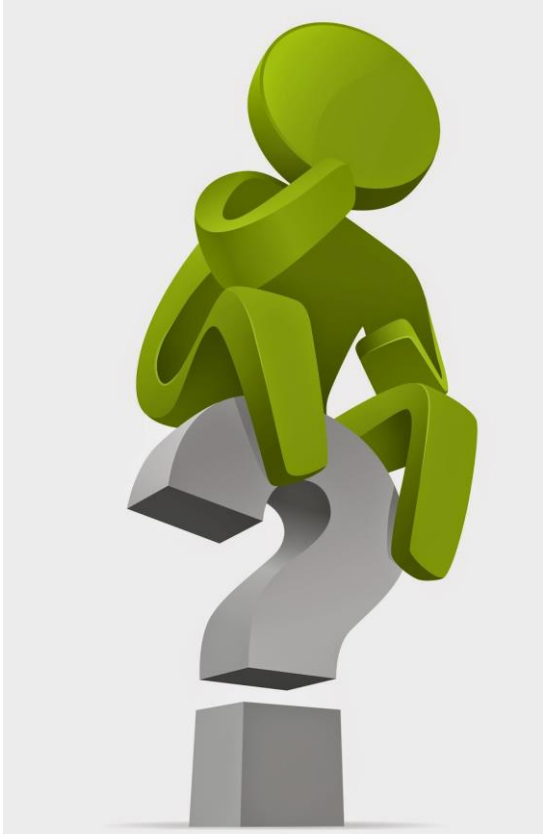

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Resources

Center for Connected Health Policy

CCHP Current Laws and Reimbursement Policies/Montana

CCHP CY2019 Medicare Changes for FQHC

Medicare Telehealth Payment Eligibility Analyzer

Northwest Regional Telehealth Resource Center

American Telemedicine Association

Medicare Learning Network Telehealth Services Document

NACHC

HRSA Telehealth Resources

CMS Telehealth MLN Document

Care Management Services FAQ

Virtual Communication Services FAQ