Financing Telehealth: A National Perspective

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Outline

I. Introduction to UMTRC
II. What is Driving Telehealth Adoption?
III. Who is Winning? How?
IV. Embracing the Future
telehealthresourcecenters.org

- Links to all TRCs
- National Webinar Series
- Reimbursement, Marketing, and Training Tools
UMTRC Services

• Presentations & Trainings
• Individual and Group Consultation
• Training and Technical Assistance
• Connections with other programs
• Program Design and Evaluation
• Information on current legislative and policy developments
Behold the Headlines

• Top Health Trend For 2014: Telehealth To Grow Over 50% (Forbes, 12/28/13)
What’s Driving Adoption?
NOT Reimbursement

• Medicare
  – Incremental expansion of 1996 law
  – About $10-15 Million payout annually

• Medicaid
  – 40+ states cover some type of telehealth

• Commercial
  – 20 states mandate commercial coverage
NOT Technology

• More reliable
• Cheaper (+/-)
• Great new cloud-based tools for small-to-medium organizations
NOT Broadband Penetration
What IS Driving Adoption?

• The Threat of Payment Reform
• Ascendancy of the Spoke Site
• The Shifting Role of the Physician
Legacy Model of Telemedicine

Historically, Telemedicine usually involved:
• A Specialty (sub-(sub-)specialty) Physician
• An Academic (or Urban) Medical Center
• “Sending Services to Needy Areas”

“The Missionary Model”
Legacy Model of Telemedicine

• Payment
  – Professional Fee to physician
    • Often from a relatively poorer payer mix
  – Facility fee ($20-25) to originating site
    • Barely covers cost of doing the billing

• Supplemented with:
  – Grant Support (hub)
  – Academic & Outreach Missions (hub)
  – IT Support (hub)
Legacy Model of Telemedicine

• Hub site could usually squeeze into the model
  – “It’s part of the mission.”

• Spoke site business was often less robust
Change Is Coming
1. Payment Reform

• Healthcare entities are businesses and respond to business pressures
  – “You get what you pay for.”

• Pay in such a way that Outcomes become more important than Procedures
  – Payment based on Results (health/function)
  – Payment based on Quality is an *interim or stopgap only*
Why This Drives Telemedicine

• “Un-billable codes” don’t matter as much
  – Freedom to “experiment” with telehealth

• Limitation: Only Partially True
  – In a Medicare ACO, only 4% of billing is in play
  – What programs can you finance for 4% of your Medicare billing?
Example: Home Monitoring

• It used to be that home monitoring wasn’t covered; now it doesn’t matter anymore

• Well designed home health programs work
  – Simpler, less expensive systems work better
  – Facilitating personal connections with caregivers (and hospital) works best

• “Using (right) tech to deliver (right) touch”

• Every stakeholder can benefit from this
2. Ascendancy of the Spoke Site

Sites that used to rely on a “hub” for services can now find and develop their own.

• Sustained need for services/clinicians
• Technology becoming more approachable
• Willingness/imperative to innovate
• Exploration of new/alternative reimbursement models where both partners benefit
Peer-to-Peer Telemedicine Project

Inputs:

• Simple equipment
• Basic training
• Ongoing access to mentoring

Result:

A collection of home grown, self-run “networks” extending practitioners into new areas and bringing them from outside areas
P2P Network(s)

- 3 CMHC
- 1 RHC
- 2 FQHC
- 1 LTC (plus MD/NP site)
- 2 CAH
- 1 Admin (Grantee)
Example – Bowen Center

- 5 sites spread across 5 counties
- 70+ miles between furthest sites
- History of specialists driving to sites
- Project began 2009
  - 2 APNs (psychiatric NPs)
  - 2 remote clinics
  - Medication evals/re-evals by TM
Bowen Center Results

Scheduled Time Converted to Billable Time

NP #1809

NP #1843

Traditional

Telemedicine
Bowen Center Results

Days to Initial Appointment

- Traditional Services
- APNs
- APNs using TM
Example – Union Hospital Clinton

CAH Tele-cardiology Service

- Patient presents in rural ED
- Evaluated by tele-cardiologist in Terre Haute
  - **High risk**: triage and transport
  - **Low risk**: imaging/labs, treat, observe, re-evaluate
Example – Union Hospital Clinton

124 Cases Evaluated for “Chest Pain r/o MI”

- Union Clinton CAH
- 119 Cases Retained, Tested, Re-evaluated

5 Transported to Terre Haute for treatment

Terre Haute Cardio

Union Hospital Terre Haute (Main Campus)
Example – Union Hospital Clinton

- **Tele-cardiology Service (2012)**
  - 124 cases evaluated (119 kept in CAH)
  - $69,000+ in additional revenue at Clinton
    - Reduced overall treatment costs to payers
  - High satisfaction for patients, families, and providers
  - Direct outreach AND rural benefit

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3. Changing Role of the Physician

- Increasingly employed (vs. private practice)
- Individual interests folded into goals of a larger (and growing) organization
- Greater flexibility in locations and settings
- Growing importance of work-life balance
- Greater comfort with technology
- Greater ability to form/sustain professional relationships at a distance
National Telehealth Bill 2013

Doris Matsui (D-Calif.) and Bill Johnson (R-Ohio) introduced the Telehealth Modernization Act of 2013 last December

**Intent:** to provide principles that states could use for guidance when developing new telehealth policies.

**Key Points the Bill Addresses:**

- **Establishing relationships:** The fundamental patient-provider relationship can be preserved, established and augmented through the use of telehealth;

- **Informing care:** A healthcare professional should have access to and review the medical history of the individual he or she is treating via telehealth;
National Telehealth Bill 2013

• **Providing documentation:** A healthcare professional should document the evaluation and any treatment furnished to the patient, as well as generate a medical record of the telehealth encounter;

• **Improving continuity of care:** Telehealth technology platforms should allow each patient the ability to forward documentation to selected care providers to **uphold the patient's continuity of care**;

• **Providing prescription requirements:** Prescriptions provided by telehealth providers should be issued for a legitimate medical purpose only and be filled by a valid dispensing entity.
National Telehealth Bill 2013

• Telehealth is adequate (when properly used) to establish and maintain a valid doctor-patient relationship

• The best healthcare is integrated healthcare; telehealth should be used to further the integration of care
Result: Innovators Are Emboldened

“First mover advantage”

• Healthcare Organizations that can respond to business pressures like good businesses can maximize their advantage

• For example...
Recruitment & Retention

Recruiting from anywhere, to anywhere

• New hires from other markets/locales
• Spouses-in-tow
• Part-timers
• Part-year, “snow birds”
• Contracting for “dirty work” (on call, etc.)
• Innovative arrangements
  – Corporate timeshare, anyone?
Paying Wholesale, Not Retail

Anthem/WellPoint LiveHealth Program

• Services provided by American Well
• Beneficiaries call directly 24/7
  – Nurse triage
  – Direct video telemedicine with doctor if appropriate
  – Co-pay (or self-pay) collected online

“End run” around brick-and-mortar docs
Convenience & Concierge

- **Primary Care Diversion**
  - Example: WellPoint (LiveHealth)

- **Work Site (Employer Owned/Contracted)**
  - Urgent/Occupational
  - Routine chronic disease care

- **School**
  - Multiple-win scenario

- **Independent Medical Group**
Programs for Special Populations

• **Inpatients**
  – Tele-hospitalists
  – Tele-ICU/NICU

• **SNF/LTC**
  – Regular appointments
  – Urgent care

• **Forensic**
  – Hearings, prison/jail
**De Facto Vertical Integration**

- Each clinical entity can “specialize” in what it does most efficiently
- Access between levels becomes easy/seamless
- “Best Practices” can develop for each niche
- ***Niche providers become interchangeable***
Vertical Integration as Best Practice
Viral Vertical Integration
UC Davis Tele-NICU Research

• Tertiary Care NICU always full
• Rural ICU always transfers some patients
• UCD specialists consult via telemedicine
• Over time, more cases are kept in rural ICU, and both sites increase average complexity

Both sites increase total revenue

Population Health Management

• Deploying the most effective programs, each at the point of its greatest impact

The most under-utilized “point of impact” is the patient in their natural environment

• Improving population health will require getting closer to the patient
  – At first, where it is most convenient
  – Eventually, where it is most effective
Population Health Management

• Benefits
  – Patient engagement/activation (clinical)
  – Patient loyalty (financial)
  – “Economies of Integration” (societal)

• Implications for Future Healthcare
  Telemedicine == Medicine
  Telehealth == Health(care)
Financing Telehealth Nationally

Financing telehealth will happen to the extent that we quit financing telehealth and just finance health.

In the future, we will:

• Measure (and buy) health, not procedures
• Empower all stakeholders to innovate
• Connect, integrate, and focus each clinician
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