

UNDERSTANDING THE WORLD OF TELEHEALTH REIMBURSEMENT

After years of great expectations, telehealth is starting to live up to its potential. Healthcare providers are turning to this form of electronic communication to assist them with patient care, while individuals are excited about the convenience, access, and lower cost of the visits.

This growth has been driven by faster internet connections, ubiquitous smartphones, and improved insurance reimbursement. In addition to ease and access to care, telehealth allows health systems and hospitals to keep pace with advancing technology and serve the social media generation. While telemedicine capabilities are some of the most exciting opportunities existing in healthcare today, inconsistent reimbursement standards continue to hinder successful program adoption. The purpose of this paper is to review the current landscape of telehealth reimbursement and provide insight into strategies for dealing with the regulatory environment.

Telehealth is most often categorized into four areas: Live Video, Store-and-Forward, Remote Patient Monitoring and Mobile Health (FIGURE 1). Each type of healthcare requires an electronic means of communication, compliant security, and, in some cases, remote devices. Several companies have emerged in each area mentioned above to accommodate the services, and today some healthcare providers have integrated well enough to offer all of them in one place.^{A, B}

A. American Well connects its doctors and patients for live, on-demand video visits online as well as handles all administrative and record keeping tasks. Recently, the telehealth company has started employing psychiatrists.

B. SnapMD's cloud-based telemedicine platforms helps providers launch their own telehealth programs and extend their points of access to care. SnapMD licensed its software nationwide.

IN THIS REPORT

- Overview of Telehealth & Reimbursement
- What's Happening Today with Telehealth Reimbursement
- Case Study: NYP OnDemand
- Future of Telehealth and Reimbursement

KEY TAKEAWAYS

- Telehealth reimbursement policies are inconsistent
- CMS Medicare coverage is limited to rural areas
- Medicaid reimbursement varies state-to-state
- Developing a telehealth program requires flexibility, creativity, and patience

FIGURE 1
The Four Main Types of Telehealth¹

Telehealth Type	Description
Live Video (Synchronous)	Live, two-way interaction between a person and a provider using audiovisual telecommunications technology
Store-and-Forward (Asynchronous)	Transmission of recorded health history through a secure electronic communications system to a practitioner or specialist
Remote Patient Monitoring	Allows for a provider to continuously track a patient's healthcare data once released to a home or care facility
Mobile Health	Healthcare and public health practice and education supported by mobile communication devices such as cell phones, tablets

Overview of Reimbursement

Though telemedicine promises to expand access and improve the quality of care for patients, providers have traditionally hesitated to adopt its use due to the uncertainty of reimbursement and compliance concerns. Compliance related regulations and requirements vary among federal and private payers. Further, states differ on how telemedicine is covered and reimbursed, and providers entering this emerging field should be aware of new policies, regulations, and other changes.²

A Variety of Telehealth Reimbursement Policies

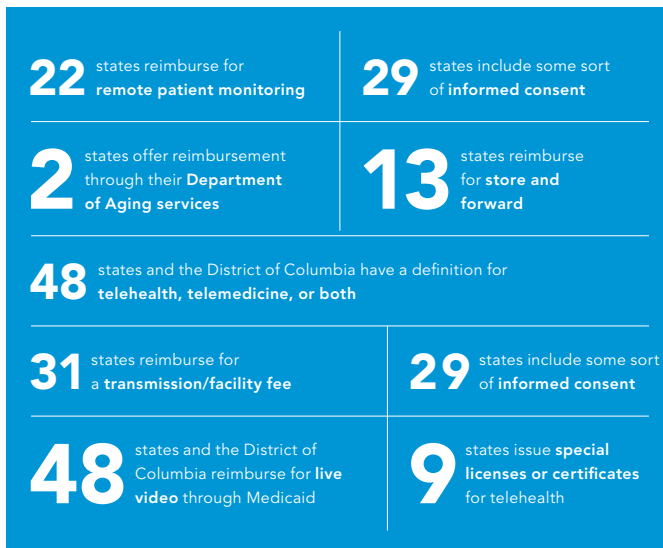
Medicaid

CMS's official policy on telehealth is that states may reimburse for telehealth under Medicaid as long as the service satisfies federal requirements of efficiency, economy, and quality of care.³ However, in Medicaid, what is required at the federal level does not determine what happens at the state level. This leaves it open for states to reimburse for telehealth as they see fit. Each state's Medicaid program has its own laws, rules, regulations, and/or policies, meaning that telehealth reimbursement is likely different in each state (FIGURE 2).

The definition of telehealth is important for Medicaid payers. CMS has emphasized its importance because telehealth is broken out into main groups: live video, store and forward, remote patient monitoring, and mobile health. There are several different telehealth policy elements that are discretionary by state (FIGURE 2).

FIGURE 2

Medicaid Reimbursement for Telehealth Services by State⁴



The regulations for the types of procedures and encounters listed below have variable, state-level coverage:

- Definition of the term telemedicine/telehealth
- Reimbursement for live video
- Reimbursement for store and forward
- Reimbursement for remote patient monitoring
- Reimbursement for email/phone/fax
- Location of service provided
- Reimbursement for transmission/facility/fees

This type of inconsistency makes it difficult for telehealth program adopters interested in developing a national service to address all of the variations. Companies have had to be very careful to study the regulations in each state and set up complaint programs.

Medicare

Medicare covers a number of rural telehealth services in lieu of in-person service including consultations, office visits, psychiatry services, and some physician fee schedule services.

These services are reimbursed at the same rate as the comparable in-person medical services. Ultimately, 80% of Medicare beneficiaries do not qualify for telemedicine services because they live in a metropolitan area.⁵ In general, telemedicine coverage and reimbursement restrictions have remained in place out of concern that the service might increase Medicare expenses due to an increase in beneficiaries' use of services.⁵

Private Payers & Telehealth Parity Laws

Commercial payers have been amongst the most aggressive in reimbursing telehealth visits in recent years. Some states are working to broaden coverage through partnerships with the number of telehealth service companies bursting their way on the scene.²

Parity laws have been enacted at the state level to prevent health plans from denying coverage or imposing additional out-of-pocket costs for virtual care. This type of law requires annual or lifetime dollar limits on telehealth benefits to be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan.

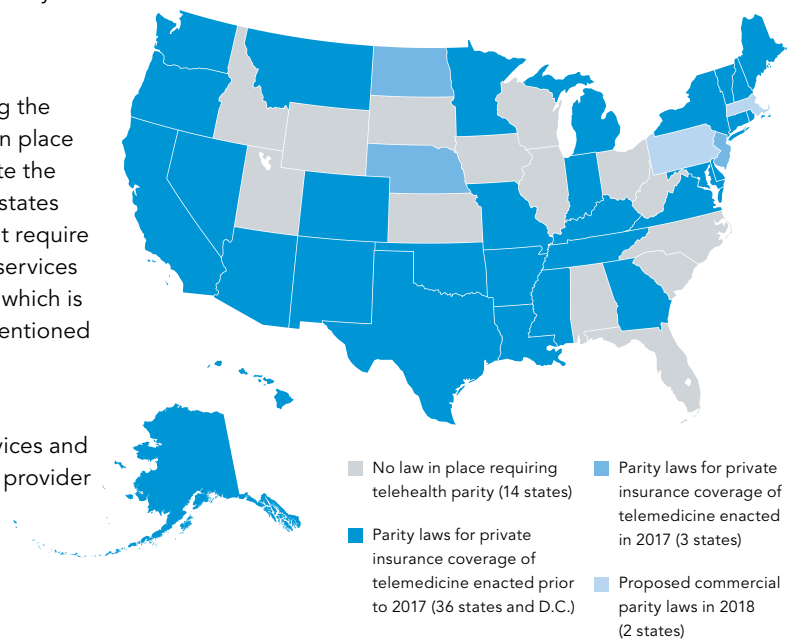
Telehealth parity laws, which generally require payers to cover telehealth services if services would be covered as provided in person, have long been trumpeted as a means to increase telehealth acceptance. Today, states are increasingly adopting commercial parity laws requiring coverage of telehealth (FIGURE 3).

To date, twenty-nine states and D.C. have enacted telemedicine parity laws that mandate private payers to reimburse as they would to in-person medical service offerings.²

Telehealth parity laws for private insurance coverage of telemedicine are currently in place in 36 states including the District of Columbia, while 14 states do not have a law in place requiring telehealth parity (FIGURE 3). It is important to note the difference from the above statement. To clarify, the 29 states mentioned in the previous have enacted parity laws that require private payers to reimburse telemedicine for the same services that would be provided in the hospital or clinic setting, which is not entirely the same representation as the 36 states mentioned (in FIGURE 3).

Similar to government programs, these parity laws are sometimes restricted by limitations on the types of services and conditions covered, patient location requirements, and provider type eligibility standards.

FIGURE 3
Parity Laws for Private Insurance Coverage for Telehealth Services⁶



In July 2016, New York-Presbyterian Health System launched a set of telehealth services – NYP OnDemand. The successful creation of NYP OnDemand allowed the hospital to troubleshoot common problems faced through new program adoption, like how to get paid. This success story will address how NYP OnDemand telehealth services worked around the tricky standards of telehealth reimbursement.

THE ISSUE: How was the hospital going to receive compensation for the telehealth services they intended on offering?

Before implementing NYP OnDemand, Presbyterian’s payer contracts did not accommodate care being delivered virtually; and understanding that Medicare reimbursement is variable at the state level and only provided in specified rural areas, reimbursement was a major challenge to the success of this program. As is the case with the majority of major technology implementations, telehealth has proven time and time again to be a significant learning process for any organization. Throughout the paper, we have learned how telemedicine reimbursement works: each state has the ability to create its own regulations, and only certain services are reimbursable, significantly contingent upon where the patient is located, particularly in rural areas. Another factor affecting reimbursement during the time of implementation was the parity law that New York state passed, stating that, “Although the law took the necessary step of protecting patients, it did not mandate reimbursement for payers, and it exempted self-insured employers all together.”⁷

What did they do?

In an effort to work around the newly passed parity law, NYP decided it would be most beneficial to implement the program with hope that reimbursement standards for telehealth would soon be atop the lawmaker’s priority list, making services more easily reimbursable.

Initially “NYP launched a telehealth based urgent care offering as a premium cash-pay service giving patients access to the Hospitals ED physicians.”⁷ Understanding that NYP OnDemand needed to offer a full array of telehealth services, the surgical platform also adopted the ability for patients to receive virtual follow-up care from such procedures.

One of the major goals of jumpstarting a telehealth program is to improve emergency department throughput, reduce overall hospital wait times and reduce potentially avoidable admissions (PAA’s) and patient readmissions. As a result, “We chose to absorb the expense of our inter-hospital digital consults, as we believe that facilitating rapid access to specialists at our community hospitals not only offers a better patient experience, but it also reduces wait times and increases emergency department throughput and inpatient units.”⁷

Did it work?

NYP OnDemand has adopted a mix of five percent technology, 15 percent process and eighty percent people. This matrix is how NYP executives designed a successful telehealth program. “Since the launch of NYP OnDemand in July 2016, it has already become one of New York Presbyterian’s core service offerings- so much so that NYP is committed to having 20% of patient encounters occur virtually by the end of 2018.”⁸

As Telehealth Evolves, What's Next?

Implementing a telehealth program demands a flexible approach, recognizing that regulation, practice, and culture will continue to evolve as telehealth becomes a generally accepted mode of care delivery. For example, NYP's hope is that their implementation of OnDemand, "fosters a virtuous cycle, whereby increased sharing the best practice on the provider side, and increased awareness and demand on the part of patients, will decrease the challenges associated with launching a program—thereby encouraging greater adoption of telehealth by patients and providers alike."⁷

While regulations are put in place to ensure care quality and safety, overly restrictive practice standards can limit the potential of telehealth to improve care delivery and population health. Beyond reimbursement, telehealth adoption and growth will depend on whether state legislatures work towards establishing parity in practice standards between virtual and in-person services.

Success has been seen with well-developed health-system conglomerates like New York-Presbyterian. They have invested large sums of capital in telehealth programs, while other systems and hospitals may not have the same capabilities. Organizations and individuals involved in telehealth transformation will continue to have to work through the challenges of reimbursement, legislation and technological infrastructure for the first time. Until there has been a proven telehealth integration method that has been uniformly successful, those involved will continue to face trial and error stages associated with different reimbursement regulations by state.

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