White Paper: Proposed Framework On Medicare Telehealth Reimbursement Models

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MAKING HEALTH CARE BETTER

ACHP
ALLIANCE OF COMMUNITY HEALTH PLANS

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PURPOSE

Why Is ACHP Offering A New Payment Model for Medicare Telehealth?

- ✓ To illustrate a financially sustainable path forward for telehealth past the public health emergency
- ✓ To ensure telehealth payment is aligned with high-quality care
- ✓ To guarantee patients, providers and payers maintain highly coordinated and convenient care for all

Barriers to Robust Telehealth Utilization

Fear of increased health care costs from Congress and the Administration.

Medicare FFS incentivizes volume over value, leading to unnecessary care and financial exploitation.

Full parity with in-person visits is not sustainable to achieve system-wide savings.

Insufficient infrastructure requiring significant investment.

ACHP's Solution

Offer a thoughtful transition process from FFS to value-based arrangements in telehealth.

Key Assumptions that Apply to Both Frameworks

Support and Reform	Prove and Grow

- ✓ The relaxed licensing guidelines for health care practitioners will not be maintained past the public health emergency
- ✓ Originating and distant site flexibilities under the public health emergency will be made permanent
- ✓ Non-physician practitioners will continue to qualify for reimbursement
- ✓ Geographical requirement that patients be located in rural areas will be removed permanently
- ✓ HHS will have the authority to issue regulatory guidance on modern technology
- ✓ Payment parity will continue for five years to allow for post-pandemic stability, adjustment and technology investment

Phased In approach to Analyze,

Build and Implement

Phase 1

- Announce that Medicare will pay full parity for telehealth services for 5 years
- National education campaign promoting virtual care

Phase 2

- Collect data to determine best balance of in-person and telehealth services post-PHE
- Independent entity analyzes data
- Public-private collaboration creates new payment model

Phase 3

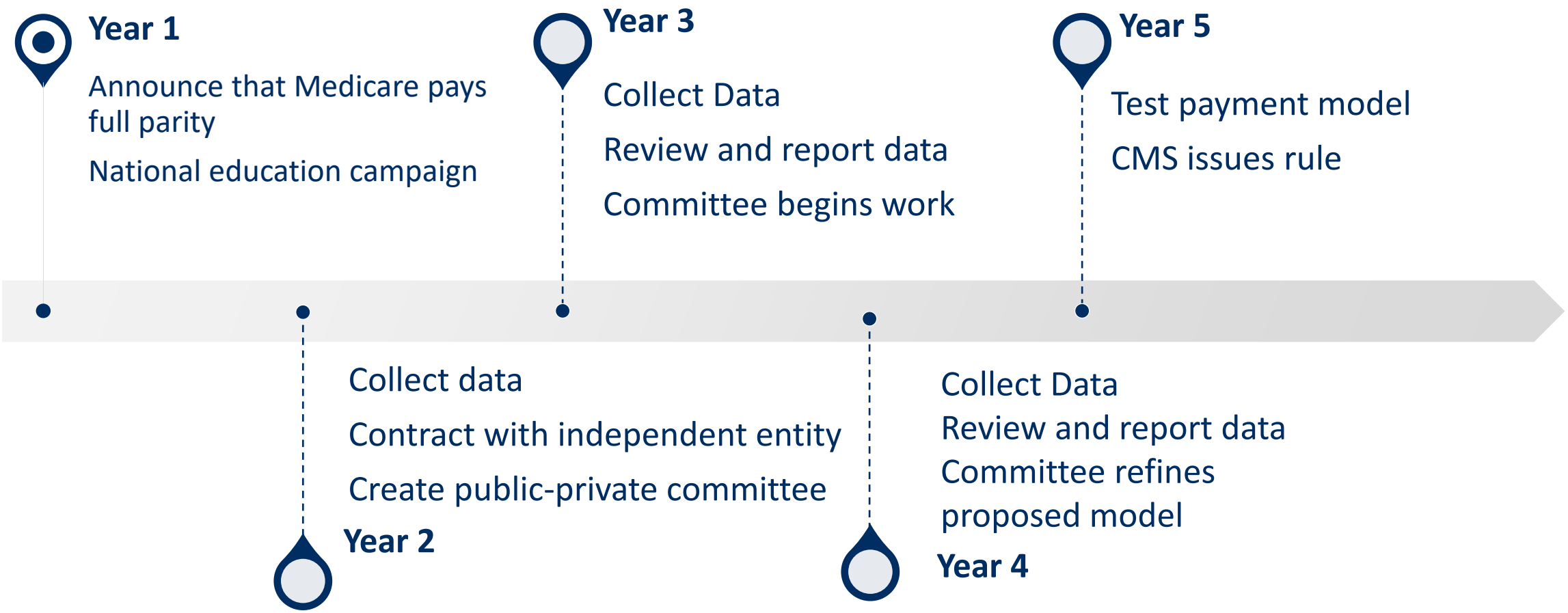
- Test payment model created by public-private collaboration in Year 5
- CMS issues proposed rule that establishes telehealth payment adjustments based on the analysis and testing in Years Four and Five

Built Upon a Matrix of Care to Evaluate Telehealth Effectiveness

The Matrix of Care would ensure that Medicare only reimburses for services that benefit patients.

- ✓ Providers will be paid PMPM w/ rewards for higher-quality services
- ✓ The type of visit is segregated into four categories:
  - Initial Intake/New Patient
  - Follow-Up Visit
  - Chronic-Care Management/Routine Visit
  - Diagnostic Visit
- ✓ These types of visits will be measured and reimbursed according to each medical specialty's effectiveness in a virtual setting.
  - Telehealth Success
  - Telehealth Potential
  - In-Person Preferable

Support and Reform Timeline



Focusing on Primary and Preventative Care

Medicare will reimburse at parity for a limited number of telehealth services for 5 years:

- ✓ Chronic care management
- ✓ Mental and behavioral health
- ✓ Follow-up / preventive care

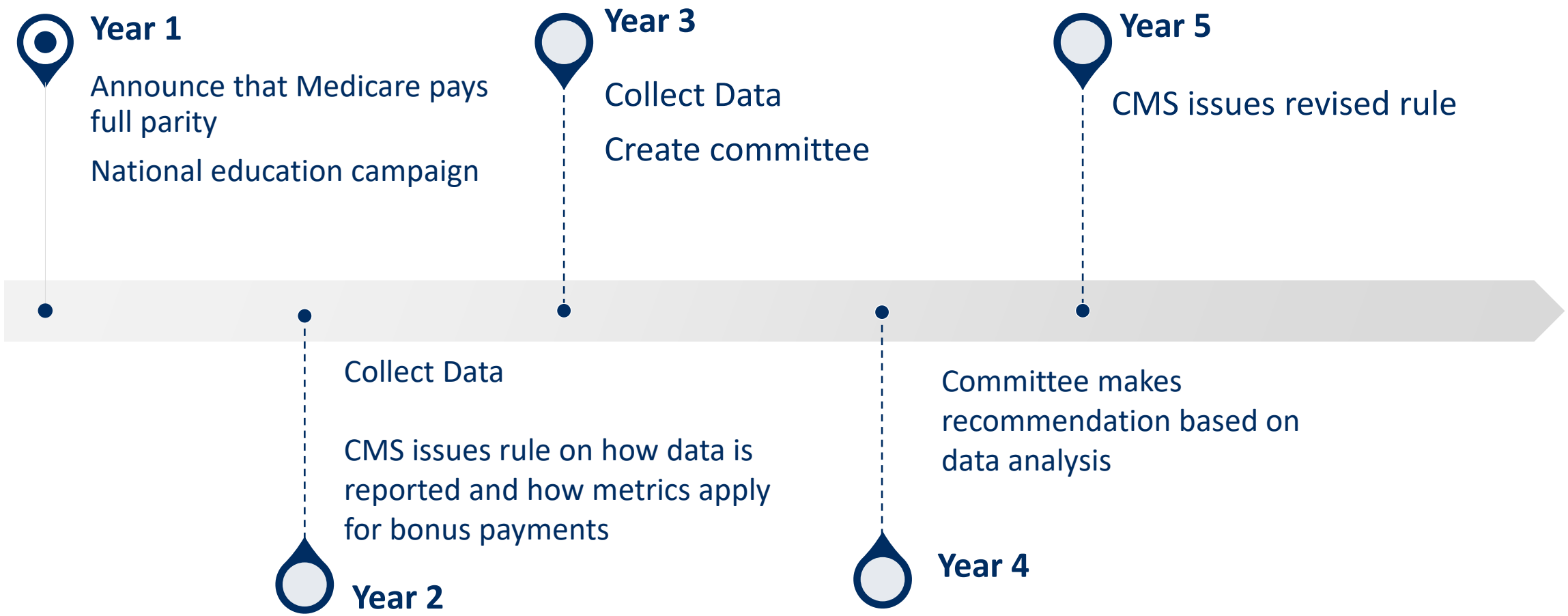
After Year Five, all telehealth reimbursements will reduce to 80% of in-person visits.

Reimbursement Based on High Quality Metrics

- ✓ **Providers will report data to demonstrate cost-effective and high-quality care**
- ✓ **Eligible to receive bonuses for high quality and lower cost services based on:**

1. Milliman Waste Calculator
2. Various Market Metrics that analyze local market cost savings based on a weighted average of metrics:
   - Patient reported outcome measures (10%),
   - Local hospital re-admission rates for in-patient care (30%)
   - No-show patient rates (20%)
   - Preventative care adoption (40%)

Prove and Grow Timeline



Additional Aspects to Consider

- Is this to address Medicare FFS or Medicare Advantage telehealth benefits?
- Is this under CMMI authority or not?
- Who collects the data? Why wouldn't you start collecting data in Year 1?
- How will providers have a predictable business model under model #2?
- Isn't there a need for capital like HITECH's funding of E.H.R. systems?