

## **White Paper: Potential Models for Medicare Telehealth Payment Post COVID-19**

October 2020

### **I. Introduction**

As the COVID-19 public health crisis continues to pressure the nation's health care infrastructure, individuals and families are increasingly turning to telehealth for safe, convenient care. The COVID-19 pandemic highlighted the need for the full and permanent inclusion of telehealth in health care delivery. While temporary waivers, guidance and interim final rules helped clear a path, communities need permanent policy to realize the full potential of virtual care. The Alliance of Community Health Plans (ACHP) nonprofit, community-based health organizations are meeting their communities' needs in this time of crisis through the many benefits of telehealth and are demonstrating the benefits of virtual care on the front lines.

The primary rationale for restricting Medicare telehealth is that it increases—rather than decreases—health care costs. The crux of this problem is a fee-for-service system that incentivizes volume rather than value. Fee-for-service health care has led to inappropriate or unnecessary care, necessitating preventive measures to avoid financial exploitation of telehealth as an additional billing code. The solution is value-based arrangements in commercial and Medicare Advantage products, which will allow for sustainable telehealth programs, putting the onus on health plans to ensure virtual care is used appropriately.

The full potential of telehealth is realized when all individuals and families can leverage the convenience and cost effectiveness of this modern modality of care. Full parity with in-person visits is not sustainable to achieve system-wide cost savings, but it will take time to transition into a permanent telehealth payment system. ACHP offers two reimbursement models that offer a path forward to develop a sustainable payment system for telehealth.

Both models include the following assumptions:

- The relaxed licensing guidelines for health care practitioners will not be maintained
- Originating and distant site guidelines under the public health emergency will be maintained
- Non-physician practitioners will continue to qualify for reimbursement
- Geographical stipulation requiring patients to be located in rural areas will be removed
- HHS will have the authority to issue regulatory guidance on modern technology

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## **II. Framework 1: Support and Reform**

The Support and Reform Framework offers holistic support to gradually reform reimbursement for selected telehealth services while transitioning to a value-based arrangement.

Initially, providers will continue to receive full parity for telehealth visits to allow for ample capital to support the necessary infrastructure to establish telehealth services appropriate to their practice. As both providers and patients become more accustomed to the quality of care and financial benefits of this delivery model, the second phase will focus on balancing in-person and telehealth to produce a workable payment model. After a testing phase, the final implementation will result in a value-based payment model that prioritizes the quality of care for patients while reducing costs regardless of the mode of services.

### **FIRST PHASE: Preparation & Information Campaign**

When the public health emergency ends, health care professionals will continue to be reimbursed at parity for at least five years. This timeframe is necessary to accomplish several goals:

- Providers must have sufficient capital to invest in the infrastructure and other resources necessary to continue and expand telehealth.
- Collection of data as non-emergency health care delivery normalizes will help plans, providers, and patients evaluate which services work best utilizing telehealth. Stakeholders will gain insights into the impact on patient outcomes and whether cost savings were realized.

This first phase will include the launch of a national educational campaign -- with public service advertisements and high-profile media outreach -- that promotes virtual care. Individuals and their families know how telehealth can mean a better, healthier life. Awareness of these benefits is key to the continued utilization of cost-effective services when in-person visits are more regularly available. Health care professionals need information and data to better understand how to track and evaluate success.

### **SECOND PHASE: Data Collection & Analysis**

Telehealth will continue to be reimbursed at parity while data on utilization is gathered. Data will be collected over the course of Years Two and Three, and the data will be submitted to an independent entity for analysis. The contractor will provide periodic reports that analyze the data to help stakeholders learn from the nationwide experience with the changing delivery system paradigm. In Year Four, the same independent entity will produce a proposal for a new Medicare payment model in collaboration with an industry stakeholder task force. This new model will function as a capitated model for



telehealth reimbursing providers on a per member per month basis. The new model would be tested in Year Five.

This transition period will allow providers to optimize their workforce and provide training, assess telehealth offerings, evaluate utilization and patient preferences and determine the appropriate balance of in-person and virtual care.

### **THIRD PHASE: Implementation**

After this five-year period, parity would be reduced via a phased approach. After the testing phase is complete (Year Five), CMS will be in a position to issue a proposed rule that establishes telehealth payment adjustments based on the analysis and testing in Years Four and Five. CMS would consider adjusting reimbursement incentives as patient monitoring, at-home testing, artificial intelligence, and other innovations continue to improve and become widely adopted. The development of a new reimbursement model -- described below as a “Matrix of Care” -- would help ensure that Medicare is only reimbursing for services that benefit patients.

### **Matrix of Care**

As part of the transition to a value-based payment model, providers will be paid a fixed amount for each patient they see – on a per member per month basis – according to a “Matrix of Care” [see Figure 1] that rewards higher-quality services with additional payments.

The matrix will group four types of services according to effectiveness in a virtual setting. 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 according to each medical specialty’s effectiveness in a virtual setting and will be categorized into three groups:

- Telehealth Success: Telehealth is consistently appropriate for the indicated service
- Telehealth Potential: Telehealth is sometimes appropriate for the indicated service
- In-Person Preferable: Telehealth is rarely appropriate for the indicated service

Each medical specialty will establish its own matrix of care – provided it adheres to the model’s framework – to determine the per member per month rate for each Specialty Effectiveness Category. For example, primary care’s chronic care management for a diabetes patient could be classified in the “Telehealth Success” category, a diagnostic visit



for a patient with an acute infection (e.g. kidney stone) could be classified as “In-Person Preferable” and an orthopedic follow-up visit for a broken bone could be classified as “Telehealth Potential.”

**Figure 1:**

		Specialty Effectiveness Category		
		Telehealth Success	Telehealth Potential	In-Person Preferable
Type of Visit	Initial Intake/ New Patient	Highest PMPM Rate	Medium PMPM Rate	Lowest PMPM Rate
	Follow-Up Visit	Highest PMPM Rate	Medium PMPM Rate	Lowest PMPM Rate
	Chronic Care Management/ Routine Visit	Highest PMPM Rate	Medium PMPM Rate	Lowest PMPM Rate
	Diagnostic Visit	Highest PMPM Rate	Medium PMPM Rate	Lowest PMPM Rate

**Methods of Measurement**

Initial methods for establishing these “Specialty Effectiveness Categories” will align with existing Healthcare Effectiveness Data and Information Set (HEDIS) measures in coordination with the National Committee for Quality Assurance (NCQA). The revised HEDIS measures published on July 1, 2020 include quality metrics for both telehealth and in-person visits. This methodology will allow for equitable and comparable measurements of both modalities of care. HHS should be able to adjust quality metrics as more relevant assessments become available.

**Payment Structure**

To incentivize physicians to provide cost-effective, quality care, visits that are classified as “Telehealth Success” will result in the highest payment rate. This additional money will allow providers to invest in infrastructure, re-deploy and train their workforce in virtual care. Visits labeled as “Telehealth Potential” will receive a slightly lower payment rate and “In-Person Preferable” will receive the lowest rate.

Mirroring [CMMI’s Primary Care First Initiative](#), Medicare will provide additional incentives for quality and value via bonus payments. Medicare will also penalize excess spending. Quality and value will be measured on a regional-based calculation and a historical-based calculation, ensuring providers are incentivized to perform better than local competitors and past performance. Both benchmarks will begin to be calculated at the end of the public health emergency and regularly reported. The benchmarks will be calculated on a 6-month rolling average to determine the relative performance locally and on a continuing basis.

Providers will be eligible to receive bonuses or owe a penalty according to the potential payments in Figure 2 below<sup>1</sup>. Providers will be eligible for 5% bonus if they advance more than two groups on the practice improvement scale in one year. If physicians provide more than 75% of care in the “Telehealth Success” category, they will be eligible for an additional bonus of up to 5%.

Visits categorized as “Telehealth Success” and “Telehealth Potential” will have an additional stipulation: if more than 50% of telehealth visit results in an in-person visit within seven days the payment rate will be reduced one level (i.e., move from “Telehealth Potential” rate to “In-Person Preferable” rate). This will reduce duplicative care.

**Figure 2:**

Regionally Based Adjustment Potential		Bonus Potential Based on Practice Improvement	
Performance Level	% of Telehealth + In-Person Payment	Performance Level	% of Telehealth + In-Person Payment
<b>Group 1:</b> Top 10% of regional practices	34%	<b>Group 1:</b> Top 10% of regional practices	16%
<b>Group 2:</b> Top 11-20% of regional practices	27%	<b>Group 2:</b> Top 11-20% of regional practices	13%
<b>Group 3:</b> Top 21-30% of regional practices	20%	<b>Group 3:</b> Top 21-30% of regional practices	10%
<b>Group 4:</b> 32-40% of regional practices	13%	<b>Group 4:</b> 32-40% of regional practices	7%
<b>Group 5:</b> 41-50% of regional practices	6.5%	<b>Group 5:</b> 41-50% of regional practices	3.5%
<b>Group 6:</b> 51-75% of regional practices	-5%	<b>Group 6:</b> 51-75% of regional practices	1.5%
<b>Group 7:</b> Practices performing at the bottom quartile of their region	-10%	<b>Group 7:</b> Practices performing at the bottom quartile of their region	0%

### III. Framework 2: Prove and Grow

The Prove and Grow framework is designed to allow for incremental growth of telehealth through the reinvestment of capital and support to specific areas of lower-capitalized types of medicine, like primary care.

<sup>1</sup> The percentages in Figure 2 are illustrative and loosely based on existing industry and CMS models.

Medicare will continue to reimburse at parity for a limited number of telehealth services: chronic care management, mental and behavioral health (non-controlled substances) and follow-up / preventive care. Comparable to Framework 1: Support and Reform, Medicare will reimburse at parity for five-years to collect data and conduct an independent study of telehealth utilization, cost, effectiveness and impact of the Prove and Grow Framework.

After Year Five, all telehealth reimbursements will reduce to 80% of in-person visits. To maintain the 80% level of telehealth reimbursement, providers must report data demonstrating that wellness and prevention strategies resulted in reduced costs associated with lower utilization of inpatient and acute care services. Providers that offer these high quality and lower cost services will be eligible for bonus payments that may be reinvested into telehealth advancements, primary care and/or geriatric care.

To calculate cost savings, CMS will utilize two measurements:

1. The [Milliman Waste Calculator](#)<sup>2</sup> to determine the percentage of services delivered over the past month classified as “necessary.”
2. Various Market Metrics that analyzes the cost-savings in a local market 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%) and preventative care adoption (40%). CMS is authorized to update weights and measurements.

Figure 3 outlines the eligibility of cost savings per measurement. Both measurements will be reported to CMS quarterly. CMS will use a 6-month rolling average on a quarterly basis to calculate each metric and determine penalties or bonus payments.

### Figure 3:

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<sup>2</sup> The Milliman MedInsight Health Waste Calculator is a standalone software tool designed to help healthcare organizations leverage value-based principles by identifying wasteful services as defined by national initiatives such as the U.S. Preventive Services Task Force and Choosing Wisely.



		<b>Milliman Waste Calculator</b>		
		<b>&gt; 75% Necessary</b>	<b>75% - 25% Necessary</b>	<b>&lt; 25% Necessary</b>
<b>Local Cost Savings</b>	<b>Top 25% of regional practices</b>	Eligible for bonus payment of 20%	Eligible for bonus payment of 15%	Eligible for bonus payment of 5%
	<b>26-50% of regional practices</b>	Eligible for bonus payment of 15%	Eligible for bonus payment of 5%	Pay penalty of 2%
	<b>51%-75% of regional practices</b>	Eligible for bonus payment of 5%	No penalty/bonus	Medicare will not reimburse – pay 15% penalty
	<b>Bottom quartile of the region</b>	Eligible for bonus payment of 2%	Medicare will not reimburse – pay 15% penalty	Medicare will not reimburse – pay 15% penalty

In Year Four, a public-private Federal Advisory Committee will make recommendations to CMS about how to continue, narrow, broaden or otherwise adjust the program to realize an improved value-based care telehealth program.

In Year Five, based on these reports and recommendations, CMS will issue a proposed rulemaking to implement a reformed Medicare reimbursement scheme for telehealth services.

#### **IV. Discussion**

ACHP continues to support innovative approaches to value-based care and payment models. The COVID-19 pandemic has pushed the health sector to new levels of care delivery, devastated systems reliant on volume and forced Administrative actions long stifled by uncertainty. These models are not intended to solve the decade-old question of how we finally shift to value in health care. Rather, these models are intended to ignite conversations and offer tangible solutions to industry partners and the Administration. Our intention is to take the first step towards rewarding virtual care and encourage all payers to make real progress in making telehealth permanent. ACHP has proposed two frameworks enabling modernization of care delivery that ultimately results in greater value. ACHP calls on industry partners and stakeholders to share in this commitment as we navigate new demands of the health care system throughout and beyond the COVID-19 pandemic.

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