Payment Policy: Digital Health and Access

Cathy J. Bradley, Ph.D.
Deputy Director
University of Colorado Cancer Center
Associate Dean for Research
(Cathy.Bradley@ucdenver.edu)

University of Colorado Cancer Center

Key Points

- Payment policies for digital health vary widely by payer and lagged relative to technology advancements
- Initially, policies aimed to increase access in remote and underserved areas and later incentivized cost reductions in health care delivery
- COVID-19 accelerated use and revolutionized payment policies for digital health visits (at least for now)
- Future payment policies have the opportunity to be in sync with increasing access and reducing costs

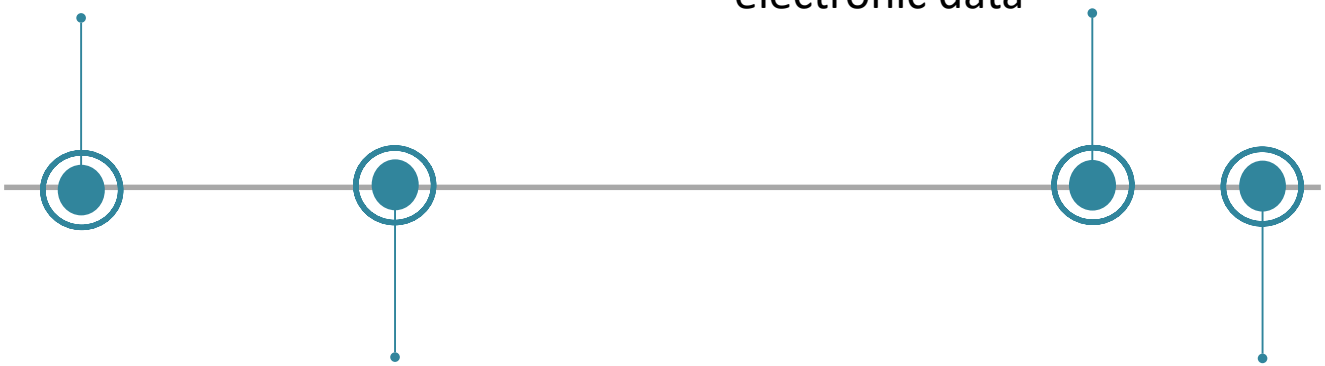
Pre-COVID payment approach to digital health

- Prior to COVID-19, telehealth visits were motivated by rural communities and health professional shortage areas
- But, inconsistent and unclear reimbursement policies across states limited its widespread adoption
- Payment varied by geography, payer, and setting
  - In absence of federal policy, states set Medicaid and private payer payment

Major digital health legislation

Balanced Budget Act (1997)
Live video visits, rural beneficiaries, no home visits; partial Medicare reimbursement

Health Information Technology for Economic and Clinical Health Act (2009)
Incentivized "meaningful use" of electronic data



The Benefits Improvement and Protection Act (2000)

Patient Accountability and Affordable Care Act (2010)
Expanded type of telehealth consultations reimbursed

Major digital health legislation

Medicare Access and CHIP Reauthorization Act (2015)

Shift to alternative payment models (ACOs); evolved from a way to improve access to a way to decrease costs

2019 Physician Fee Schedule

Check-ins and "Store-and-Forward"

Bipartisan Budget Act of 2018

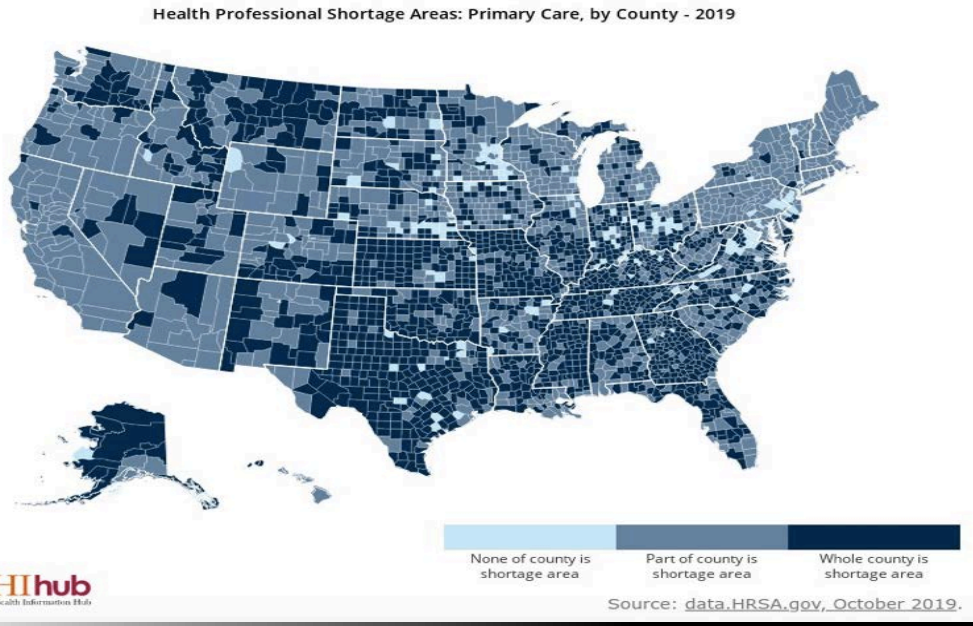
Allowed home visits; eliminated geographic restrictions for ACO beneficiaries

Technology and Policy Out of Sync

- Digital Health Innovation Exploded
- Payment Policy and legislation lagged

Medicare payment policies (pre-2019)

- Only reimburse for synchronous communications (live videos)
- Reimbursements for non-Metropolitan Statistical Areas and Health Professional Shortage Areas



Medicare payment policies

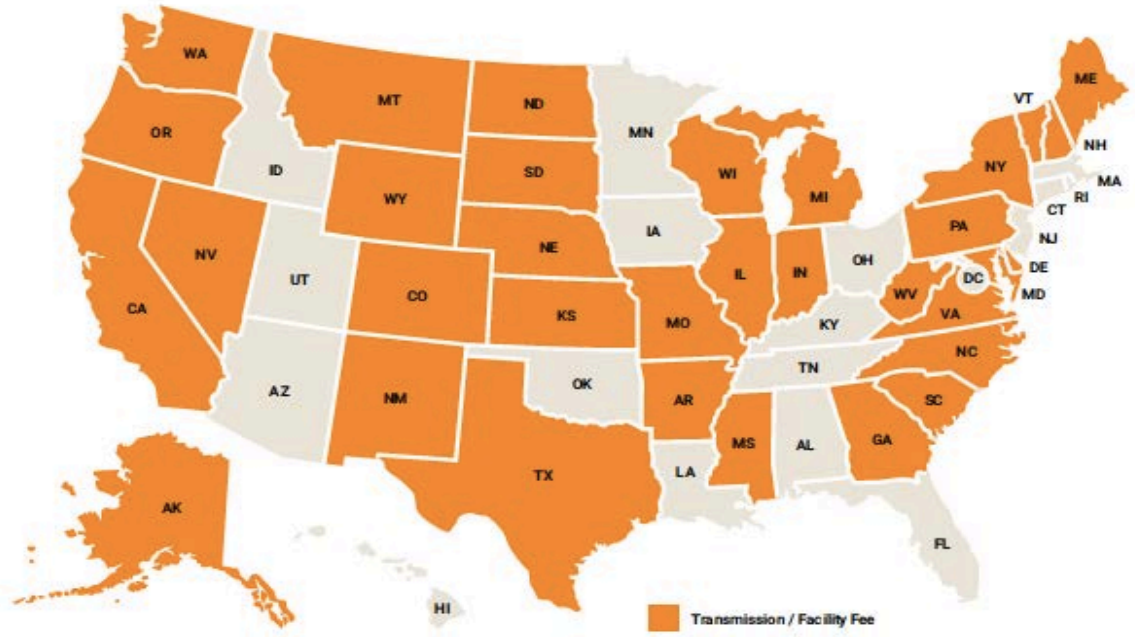
- Patient must be at an eligible originating site for provider reimbursement
  - No reimbursement if patient was at home
- Some digital health reimbursed through chronic care payment codes, including synthesizing and interpreting data generated remotely (not telehealth codes)
  - Oncology not included

Medicaid payment policies

- All 50 states & DC have provide some level of telehealth services
- 16 states reimburse for store-and-forward
- 23 state Medicaid programs reimburse for remote patient monitoring
  - RPM in oncology is billable in Texas and Missouri, if determined cost-effective
- Trend toward expanding list of eligible providers or eliminating the list altogether

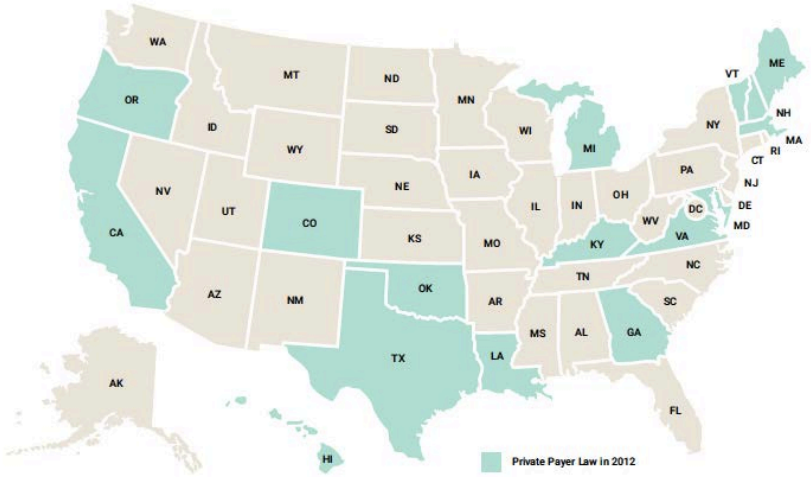
Medicaid payment policies

- 43 state programs reimburse a transmission or facility fee when telehealth is used
- Only 19 states allow home to be originating site

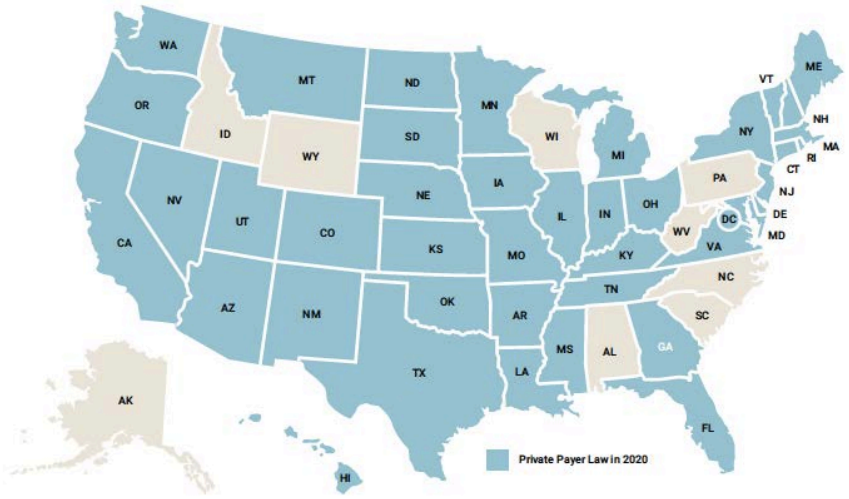


Private payer policies

Private Payer Law Map in 2012:



Private Payer Law Map in 2020:



2012

2020

42 States & DC have private payer parity laws for telehealth services

COVID-19 Revolutionized payment policy

- Large increase in digital health utilization (600%+)
- CMS waiver allows Medicare, Medicaid, CHIP providers to conduct digital health
  - New and established patients
  - Bill across state lines
  - Outside of rural health areas

Rapidly revolutionized payment policy

- CMS expanded list of Medicaid covered services
- HHS temporarily waived HIPPA regulations for consumer communications
  - Zoom, Facetime
- Private insurance expansion of digital health
  - Eliminating co-pays associated with telehealth
- *New policies due to COVID will expire after the pandemic*

Post-COVID payment policies impact on access

- Accelerated use of telehealth, reducing barriers for all patients
- Benefit may be greatest for those in severely compromised health
- Opened the way for widespread use and future expansion
  - Socialized across specialty care and became more acceptable for oncology care

Adoption and access

- System-owned hospitals; part of a network
- Major teaching hospitals
- Providers engaged in Alternative Payment Models and Accountable Care Organizations
  - 2x more likely to provide telehealth services
  - Treat vulnerable patients (low-income, dually enrolled, racial/ethnic minority, high risk; Werner et al., 2019; Lee et al., 2020)

Less likely to adopt digital health

- Government-owned facilities, with the exception of teaching hospitals
  - Primarily serve low-income or uninsured patients
- For-profit hospitals
  - Wealthier patients, more elective procedures
- States that require out-of-state providers to have a special license

Policy barriers for provider participation and options for reform

Caveats

- Still lack a strong evidence base
  - Quality of care
  - Outcomes
  - Cost-effectiveness accounting for full economic cost to patients and providers
- Call for more research

Policy Gaps Remain

- Limited or inconsistent reimbursement persists
- Wide variation in amount reimbursed for similar services
- Remote patient monitoring inconsistently reimbursed
  - Only 2 states list oncology as a reason for RPM

Policy Recommendations

- Extend post-COVID waivers
  - Remove originating site restrictions
- Consistent reimbursed services
  - Expand list services; Include RPM
  - Expand scope of practice policies
- Guidelines for reimbursed services (whether parity or something less)
- Remove restrictions for providers to practice across states
- Incentivize more widespread adoption through Alternative Payment Models or other methods such as the Federal Communication Commission's payments to new telehealth providers

Questions?

Cathy.Bradley@ucdenver.edu

University of Colorado
Cancer Center