Telehealth Post Public Health Emergency: Business Realities and Strategies

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Objectives

- Discuss current state of EM telehealth and evolution since PHE
- Review telehealth reimbursement models
- Discuss use cases and real world experience with starting and maintaining these programs

Telehealth 2019 B.C. (Before COVID)

Primarily focused on low acuity, non emergency conditions

- On demand, application based, payment upfront
  - Express Care Online, Teladoc, AmWell
- Second opinions
- Office based alternatives
- Chronic disease management programs

Geographical requirements limited utilization

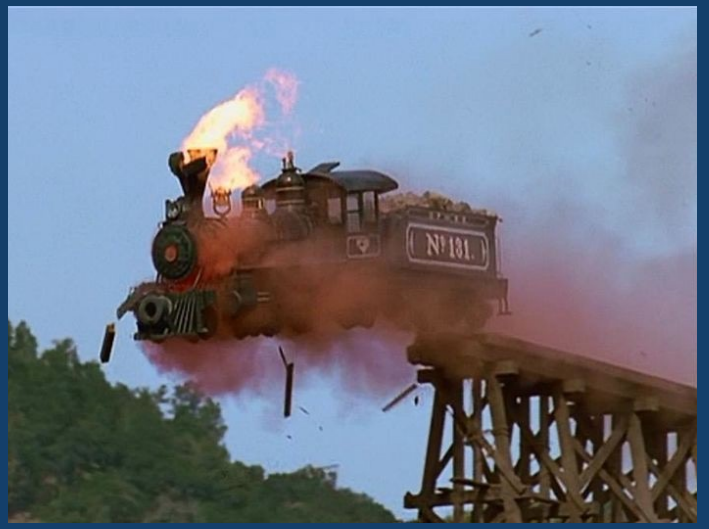
Reimbursement challenges

- ED E/M codes excluded
- Call9 case example

CMMI introduced ET3 model

Telehealth 2020

- COVID 19 hits and public health emergency declared
  - Virtual encounters can be initiated at home
  - Geographical waivers lifted
  - State licensure waivers
  - ED E/M codes can now be reimbursed virtually
  - No co-pay for virtual encounters
  - Commercial payers follow suit

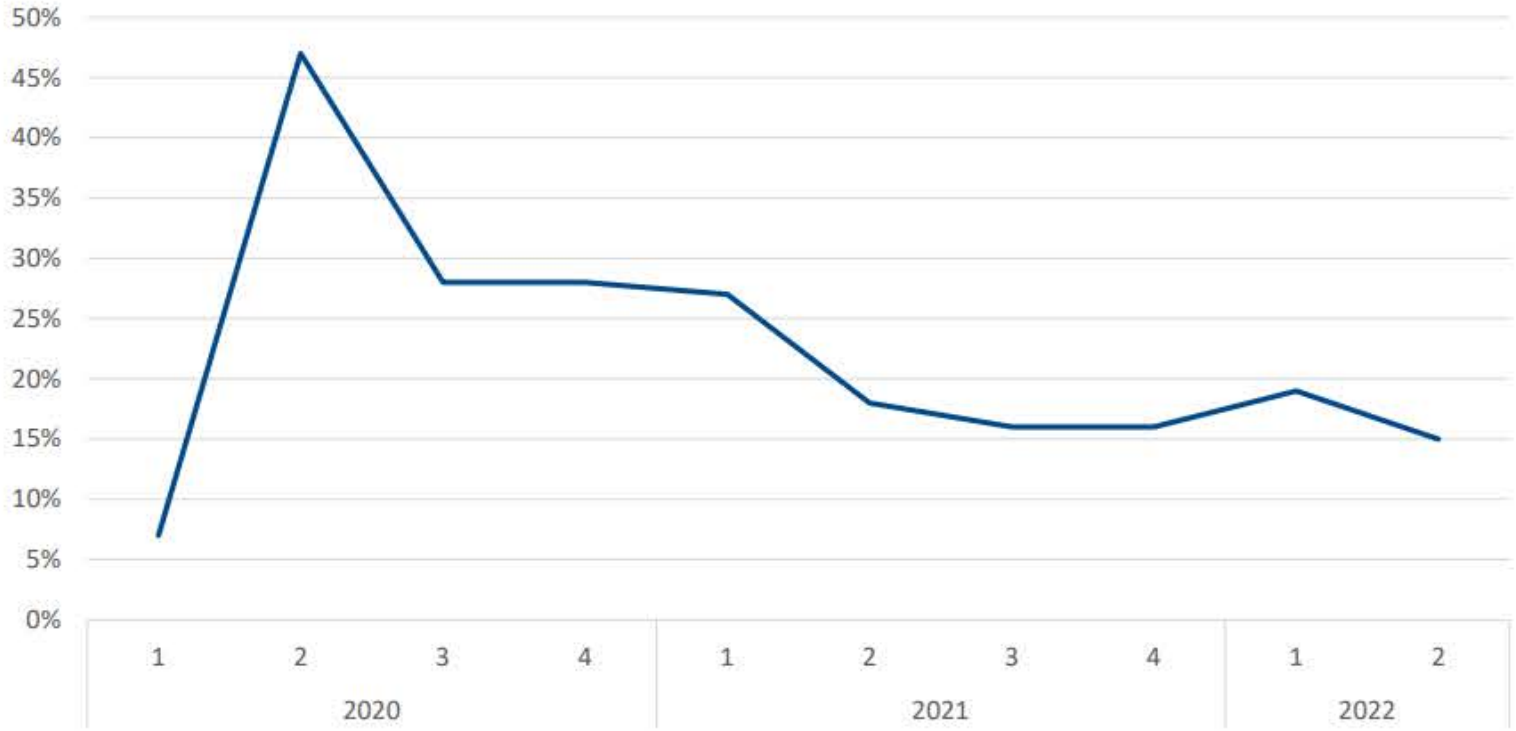


- Explosion in telehealth utilization

Medicare Telehealth Trends Report

Medicare FFS Part B Claims Data: January 1, 2020 to June 30, 2022, Received by November 11, 2022

Percentage of Medicare Users with a Telehealth Service by Quarter: Overall



Disclaimer: All data presented in this report are preliminary and will continue to change as CMS processes additional claims for the reporting period.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Telehealth Trends Report

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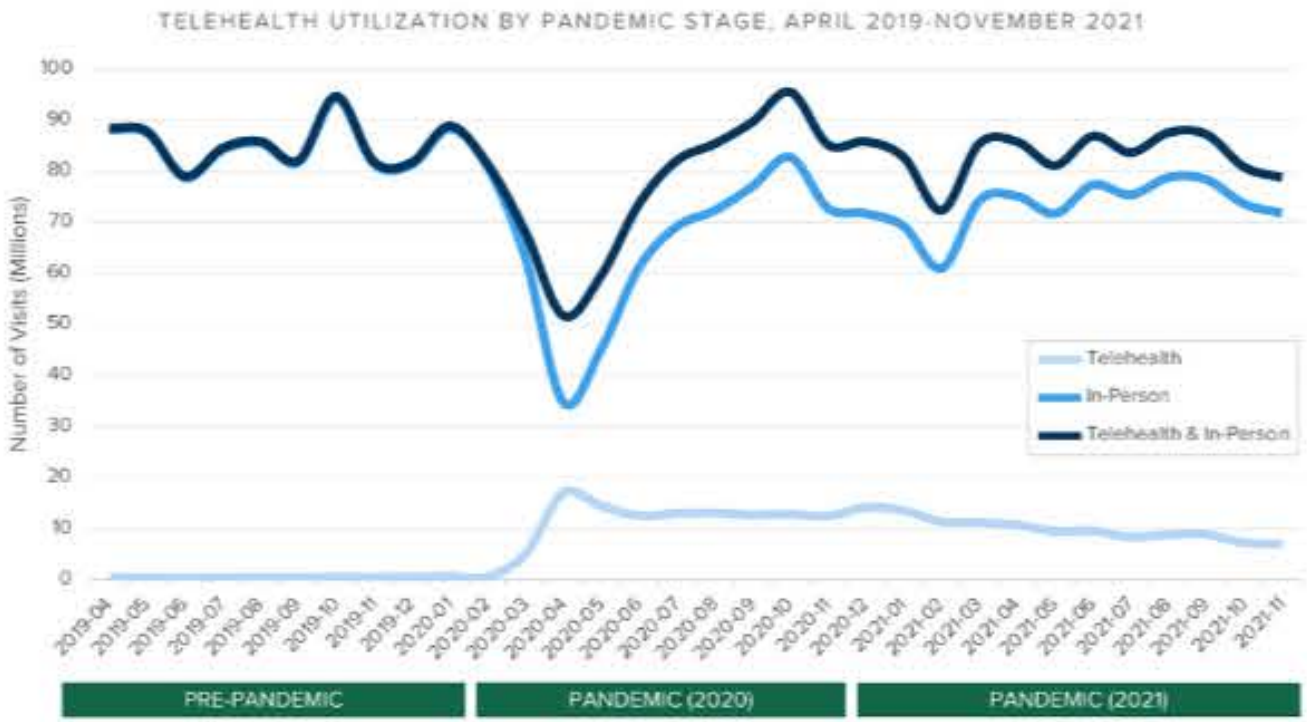
DEMAND: VOLUME

Telehealth and In-Person Visits Have an Inverse Relationship

In April 2021, in-person visits and total visits were 14.8% and 3.1% lower, respectively, than in April 2019. Telehealth visits in April 2021 declined 37% from April 2020.



Note: Our estimates do not account for self-pay telehealth encounters, telehealth encounters at no cost through commercial insurers, nor from a representative sample of traditional Medicare.
Source: Trilliant Health national all-payer claims database.

FAIR Health
Know Your Source

Monthly Telehealth Regional Tracker, October 2022

United States

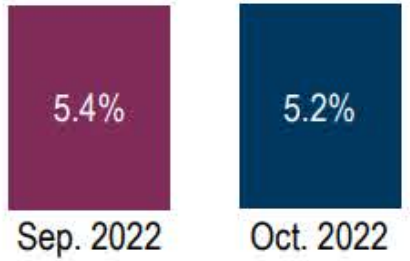
Top Five Procedure Codes by Utilization

In order from most to least common

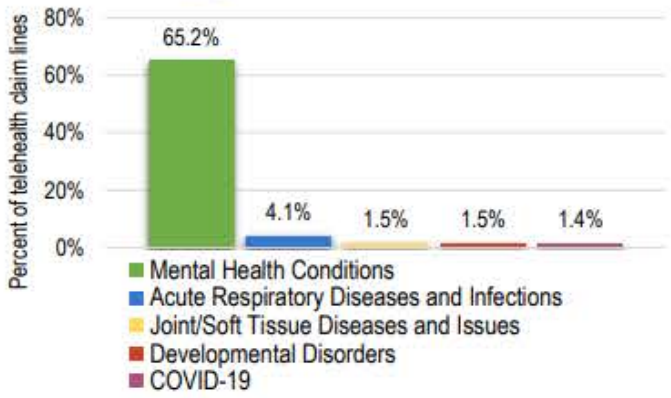
CPT®/HCPCS	DESCRIPTION	PERCENT OF TELEHEALTH CLAIM LINES
90837	PSYCHOTHERAPY, 1 HOUR	27.4%
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, 30-39 MINUTES	15.1%
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, 20-29 MINUTES	13.4%
90834	PSYCHOTHERAPY, 45 MINUTES	11.1%
90833	PSYCHOTHERAPY WITH EVALUATION AND MANAGEMENT VISIT, 30 MINUTES	4.3%

Percent of Medical Claim Lines

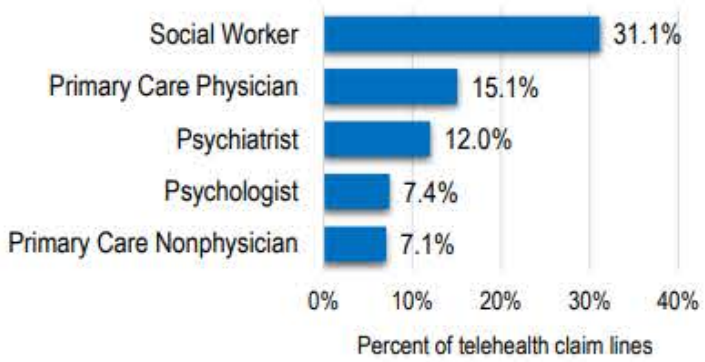
Percent Change (Sep.-Oct.)
-3.70%



Top Five Diagnoses



Top Five Specialties



Telehealth Cost Corner

CPT®/HCPCS	DESCRIPTION
90833	PSYCHOTHERAPY WITH EVALUATION AND MANAGEMENT VISIT, 30 MINUTES

MEDIAN CHARGE AMOUNT	MEDIAN ALLOWED AMOUNT
$126.20	$77.70

Omnibus Spending Bill: Telehealth Changes

- Telehealth flexibilities now in effect through end of 2024
  - Removes 151 days after end of PHE caveat
    - **Originating site includes any site where patient is located including patients home**
    - Extends ability for FHGs and rural health clinics to furnish telehealth services
    - Delays 6 mo requirement for in person mental health services furnished through telehealth
    - Extends coverage and payment for audio only
    - Extends ability to use telehealth to meet face to face recertification requirement for hospice care
    - Extends temporary telehealth safe harbor for high deductible health plans
  - Hospital at home program also extended to end of 2024

EM Specific Telehealth Reimbursement

- 99281-99285 can be used through end of 2023
- Use POS #23 when billing for telehealth services
- Use modifier 95
- Only need to report as telehealth services if individual physician or professional is not in the same location as the beneficiary

Virtual EM Program Background

- New to the telehealth space
- Focused entirely on emergency medicine telehealth
  - Patient facing partner approach
- Excluded express care online model

Virtual EM Program: Where we started

Cleveland Clinic Emergency Services Institute:
- Zero virtual visits pre-pandemic

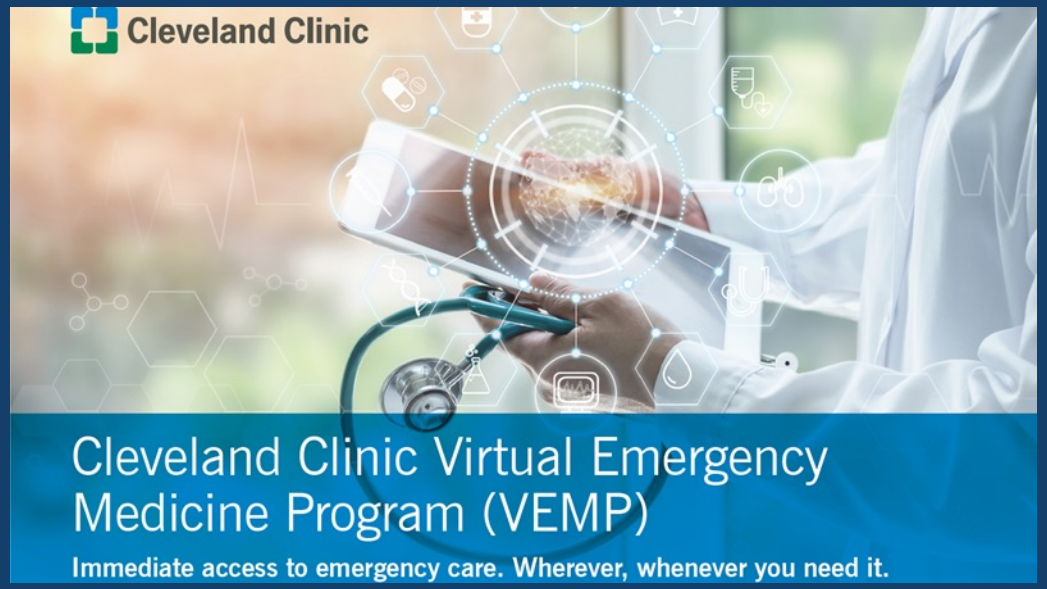
Organizationally robust: Express Care Online

Pre COVID 19
- ET3 participant/partnership

COVID 19
- In ED trial
- Tent trial
- EMS

Virtual EM Program: Where we landed

- 24/7/365 board certified EM physician coverage
- ET3 Support and non ET3 EMS Expansion
- Virtual Triage
- Congregate Care Space
- Express/Urgent Care Triage
- Value Opportunities/Partnerships



Use Case Review

- CMMI Emergency Triage, Treat, and Transport (ET3)
- ED Triage
- Congregate Care

Table 1. Example of Possible ET3 Payment Scenarios

INTERVENTION	PAYMENT	
	Participant	**Non-Participant Partner**[7]
Transport to Alternative Destination	BLS-E or ALS1-E base rate + mileage and adjustments[8]	Medicare billed for services furnished under the applicable FFS rules. Payment amount depends on service rendered at the alternative destination site.
Treatment in Place (qualified health care practitioner, via Telehealth)	Payment equal to BLS-E or ALS1-E base rate = Telehealth originating site fee + modifier to equal BLS-E or ALS1-E base rate	Medicare billed under Physician Fee Schedule for telehealth services furnished Payment = Medicare Physician Fee Schedule amount for furnished service
Treatment in Place (qualified health care practitioner, in-person)	Payment = BLS-E or ALS1-E base rate	Medicare billed under Physician Fee Schedule for services furnished Payment = Medicare Physician Fee Schedule amount for furnished service

ET3 Reimbursement/Modifiers

- Ambulance billing
  - Destination modifier W for treatment in place or telehealth
  - Refusal of ET3 intervention: G2022 modifier
- Qualified Healthcare Practitioner billing
  - POS modifier: 02 – telehealth
  - ET3 Model specific G code: G2021 TIP
  - After hours (8p -8a): UJ modifier = 15% increase in reimbursement
  - Must be on partners approved QHP list

ET3 Results

Model Interventions occurring between **January 1, 2021** and July 31, 2022.

Model-Wide Performance Data (January 1, 2021 through July 31, 2022)	
Number of Participants who have submitted at least one properly billed ET3 Model claim	47
Number of unique Medicare Fee-For-Service beneficiaries who have received at least one ET3 Model Intervention	1,483
Average number of days from Transport to Alternative Destination (TAD)/Treatment in Place (TIP) Intervention Date of Service (DOS) to claims submission	81
Percentage of observed Emergency Department (ED) visits within three days of a TAD Intervention	36%
Percentage of observed ED visits within three days of a TIP Intervention	27%
Percentage of observed ED visits within three days of a TAD/TIP Intervention	28%
Number of TAD/TIP Interventions paid (Medicare FFS)	1,636

ET3: Our experiences

- Alternative destination capacity and hour limitation
- Consent
- Payer agnostic approach v Medicare FFS Identification
- Volume implications
- EMS agency challenges

ET3: Our experiences

- Slow to start
- ~ 3-5% of call volume
  - Varies by partner
- > 70% TIP success
- Variable realization rates on commercial reimbursement

Payer	% of EMS transports (traditional)	% of ET3
Medicare	66%	41%
Medicaid/Self Pay	14%	44%
Commercial	20%	15%

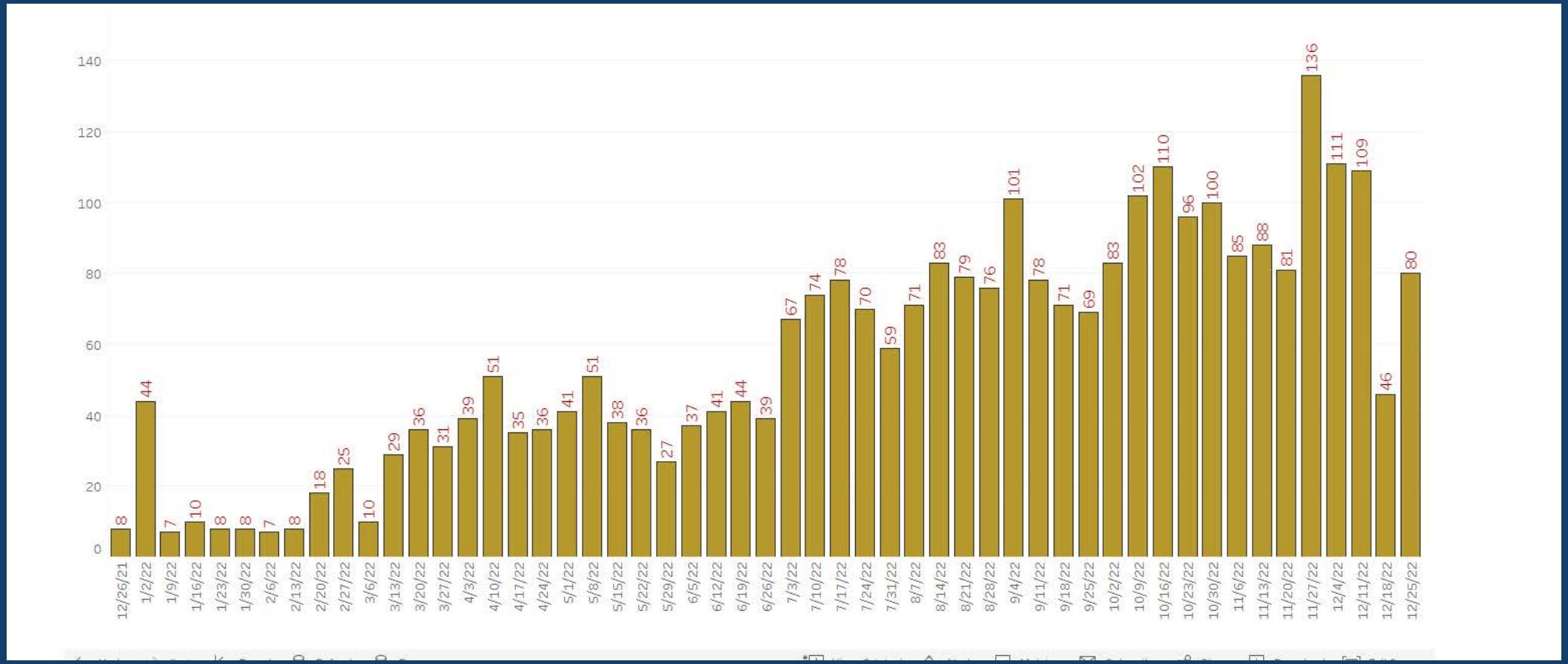
ET3 Conclusions

- Majority of EMS agencies are not equipped to participate meaningfully in CMMI model
  - Administrative work
  - Government speed
  - Cost
- Non Medicare payer support for EMS
- Paramedic buy in continues to be challenging
- Competing interests of health system and physician group partners make it difficult for agencies to find partners
- Medicaid space is likely where the greatest opportunity lies
- Targeted EMS partnerships outside the ET3 model may be where there is some opportunity/impact

Virtual Triage

- Born out of COVID surge in Dec 2021
- Has been primary focus now with record boarding and LBTC numbers
- Single provider supports multiple regional EDs
- Primary focus on low acuity dischargeable patients
- Order entry/workup initiation
- Quality impacts
  - Eyes on the lobby

Virtual Triage



Virtual Triage: Reimbursement Realities

- Professional and technical revenue generated
- Realization rate similar to typical ED numbers
- Most commercial plans pay
- Operational value
  - Throughput
  - Reduction in LBTC
  - Patient experience

Payer	ED %	Triage %
Medicaid	32%	54%
Medicare	33%	12%
Commercial	30%	25%
Self Pay	5%	9%

Congregate Care

- Highly variable utilization giving nursing workforce implications
- Reimbursement models can vary
  - Subscription
  - Fee for service
  - Value
- More predictable payer mix

What about on demand services?

- Not a part of our model
- For most groups this probably makes sense
- Payment upfront
- No required partner
- Clear business model

Note: Dates notate when company began offering telehealth services.
Source: Publicly available company information.

Early reimbursement conclusions

- Fee for service is not sustainable in most models for non on demand services given payer mix
- Enormous cost savings for payers
  - 10X in Medicaid space on avoided ED visit
- Clear opportunity for value arrangement
  - Lump sum
  - Enhanced FFS
  - Shared savings
  - Capitation
- Health System impact
  - Avoiding ED utilization for right patients
  - Reduction in LBTC impact
  - Technical fee impact

The Value Play

- Partner dependent
  - High Medicaid population?
  - Employers?
- ACO
- How do you target these patients?
- Geographical implications for groups
- Hospital partner implications

Rethinking ED Volumes:
They don't teach sales in medical school

- Ambulatory approach of building patient base
- Reliant on patient facing partners
- Diversifying the portfolio
- Uncompensated care risk tolerance
- It takes time to build a practice

Where do we go from here?

- Telehealth volumes are decreasing from surge during early PHE
- Numerous product offerings/services has led to significant industry redundancy
- Supply/demand mismatch likely to occur
- FFS model likely not sustainable for traditional E/M
- Value opportunity in Medicare/Medicaid provides opening to reshape reimbursement
- Continue to bring Emergency Medicine outside the walls of the ED

Thank You