Connected Health Care: Payer's Perspective

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Role of HHS/CMS – Medicare Coverage

- Medicare coverage and payment rules are based on whether a product or service fits into a covered benefit category.
  - Most categories defined in § 1861(s).

- "Reasonable and necessary" requirement: Medicare may not pay for expenses of items and services that are not "reasonable and necessary" for the diagnosis or treatment of illness and injury. § 1862(a)(1)(A).

- National Coverage Determinations (NCDs)
  - Rule adopted by CMS that specifies whether CMS will or will not cover specific items and the circumstances under which they may be covered
  - Establish a substantive legal standard for Medicare coverage CMS typically makes only 20-30 NCDs per year.

- Local Coverage Determinations (LCDs)
  - Most coverage decisions are made through LCDs at the local level by Medicare contractors
  - The Medicare Program Integrity Manual (PIM) lays out criteria including that items or services receiving LCDs must be safe and effective; not experimental or investigational.

Role of HHS/CMS – Medicare Payment

- Medicare Payment
  - Medicare pays providers for products and services furnished to Medicare beneficiaries based on payment systems, which fall into six major groups including
    - (1) inpatient acute care; (2) ambulatory care furnished by physicians, hospital outpatient departments, ASC, and clinical labs; (3) post-acute care furnished by SNF, home health agencies, inpatient rehabilitation facilities and long-term care hospitals; (4) dialysis services; (5) ambulance services and products furnished by DME suppliers; and (6) services furnished by private health plans under the Medicare Advantage program.
  - In traditional fee-for-service (FFS), Medicare sets payment rates prospectively and providers receive these rates for most covered products and services.
  - The Physician Fee Schedule (PFS), for example, lists the maximum fees CMS will use for reimbursing a provider. The PFS lists more than 7,000 covered services including office visits, surgical procedures, and diagnostic and therapeutic services, which can be furnished in many settings such as the physician's office, hospital, beneficiary's home, and other settings.

Reimbursement of new technologies

- Coverage. To receive Medicare reimbursement for new technologies, the technology would need to fit into a Medicare covered benefit, and be "reasonable and necessary" for the diagnosis or treatment of illness or injury.

- Coding. The new technology will also need a code under which its services can be billed– either fit into an existing CPT (Current Procedural Terminology) code or, initially, use a nonspecific code.

- Payment. Payment rates under FFS, based on a base payment rate, relative value units (RVUs) based on resources required, physician conversion factor (CF) for the year, and geographic practice cost indices (GPCI), to adjust for variances in geographic markets.

Remote Care Delivery – Government Perspective

- CMS pays for certain telehealth services.
  - Payment for telehealth started with provisions included in the Balanced Budget Act of 1997, which mandated that Medicare reimburse for telemedicine care and fund telemedicine demonstration projects.
  - Generally, "The Secretary shall pay for telehealth services that are furnished via a telecommunications system by a physician … or a practitioner … to an eligible telehealth individual enrolled under this part notwithstanding that the individual physician or practitioner providing the telehealth service is not at the same location as the beneficiary. Social Security Act, §1834(m).

- Medicare
  - Medicare defines telehealth services at 42 CFR 410.78 (as required at §1834(m)(4)(F)).
  - Medicare will make any additions or deletions to the list of services defined as Medicare telehealth services effective on a January 1st basis.
  - The vehicle for such changes is the annual physician fee schedule rule.

- Medicaid
  - The Federal Medicaid statute (Title XIX of the Social Security Act) does not recognize telemedicine as a distinct service, however, for purposes of Medicaid, CMS views telemedicine "as a cost-effective alternative to the more traditional face-to-face way of providing medical care that a state may choose to cover."
  - Reimbursement for Medicaid covered services, including those with telemedicine applications, must satisfy federal requirements of efficiency, economy and quality of care.

Remote Care Delivery – Government Perspective (cont.)

- CMS does not have an established national policy on remote-monitoring services, however codes were created in the 2009 Physician payment rule for remote monitoring where the service met certain criteria.

- Local CMS offices may pursue local coverage determinations for remote services.
  - CMS issued a program transmittal in 2006 which provided direction to local carriers regarding coding for remote monitoring.

- CMS demonstration projects would be an alternative way to get CMS to pay for remote-monitoring services.
  - In 2000, CMS began a 4-year demonstration project, “Informatics for Diabetes Education and Telemedicine (IDEATel) Demonstration Project” which was extended for another 4 years in 2004.
  - There are no current ongoing CMS demonstration projects on remote-monitoring services.

- Federal Funding in the Stimulus bill
  - The American Recovery and Reinvestment Act of 2009 provided $2.8 billion in funding to Rural Broadband Infrastructure Development, including a provision encouraging the promotion of telemedicine.

Health Reform and Connected Health Market

- Health reform could be a potential vehicle for incorporating new payment method aimed at increasing adoption of telemedicine and telehealth.
  - Already, some providers are using telehealth technologies. For example, the Berkshire Medical Center in Massachusetts has put into place a $55,000 telephone system that relays patients' daily weight, heart rate, oxygen levels and blood pressure.
    - *Cutting Repeat Hospital Trips -- Simple Idea, Hard to Pull Off,* WSJ, 7/28/09.

- Senate status –
  - There were no provisions on telehealth or telemedicine in the HELP Committee's health reform bill, the options papers released by the Finance committee earlier this year, or Baucus's health reform outline released in the beginning of September.
  - There is a possibility that provisions could be included in the Senate Finance Committee bill, still under discussion and development.

- House status – America's Affordable Health Choices Act of 2009
  - SEC. 1191. Telehealth Expansion and Enhancements. Provision would establish a Telehealth Advisory Committee, which would make recommendations to the Secretary regarding the delivery of telehealth services.
  - SEC. 1639. Face to Face Encounter Required Before Physicians May Certify Eligibility for Home Health Services or Durable Medical Equipment Under Medicare. Provision would include use of telehealth in the "face-to-face encounter" requirements.

Health Reform and the Connected Health Market

- Both House and Senate versions of health reform legislation envision Medicare moving to different reimbursement models
  - Medical homes
  - P4P
  - Bundling/global payments
- In addition, the Massachusetts Special Commission on Health Care Cost Containment has recommended that all health care payments to Massachusetts health care providers be a global payment
  - Including Medicare and Medicaid, so federal waivers would be required.
- Questions for consideration
  - Will innovative payment structures such as these encourage or discourage adoption of connected health technologies?
  - Will Medicare act as an innovator or will private insurers act first?
  - What standards will the federal government use to grant waivers to Massachusetts?