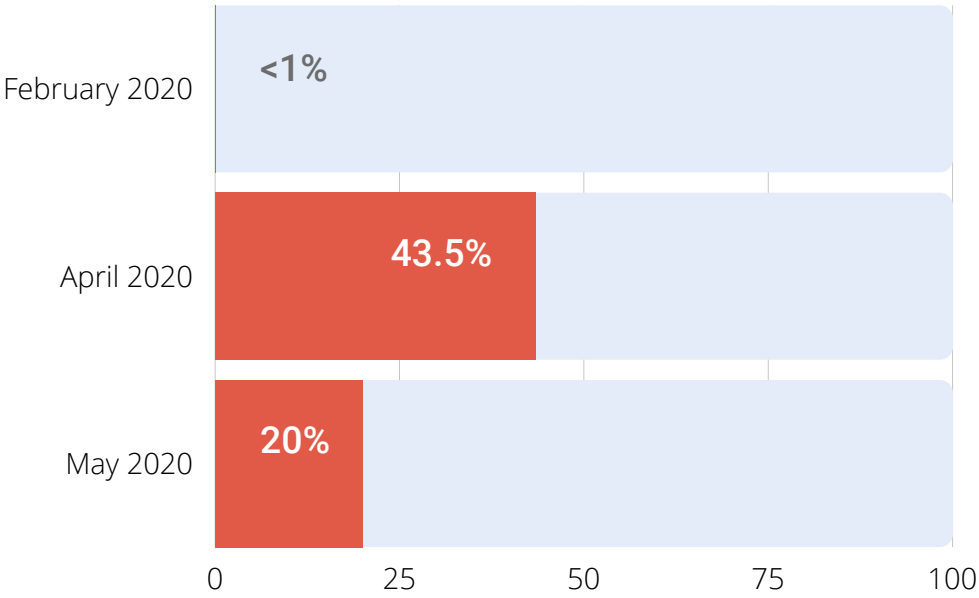
Getting the price right:

Looking toward the future of telehealth

The COVID-19 pandemic forced the US health care system to innovate in how patients access care. Due to stay-at-home restrictions, social distancing requirements, and general fear of being in public, the broad use of telehealth in Medicare beneficiaries took off. In April 2020, 43.5 percent of primary care visits under Medicare were provided via telehealth, compared to 0.1 percent in February 2020. By May 2020, the proportion of primary care visits being conducted through telehealth fell to 20 percent. A full year later, as the country continues to reopen and vaccines are administered, Aledade's data shows that roughly 10 percent of visits are still being conducted through telehealth, though some practices are still seeing rates as high as 70 percent.

The pandemic has shown us that giving providers and patients more flexibility with how they can receive care via telehealth increases access to quality care. This is especially true for patients attributed to primary care organizations participating in risk-taking value-based care models. The Centers for Medicare and Medicaid Services (CMS) recognized the lifeline telehealth provided during the pandemic, and has proposed in the 2022 Physician Fee Schedule to extend the list of codes allowed during the Public Health Emergency (PHE) through the 2023 calendar year. While this is a welcomed proposal, Congress must act to keep the geographical and originating site restrictions from ending at the conclusion of the PHE. As we think about moving beyond

Percent of primary care visits under Medicare provided via telehealth



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the public health emergency, and assume that Congress will do the right thing and provide the necessary statutory changes to allow Medicare beneficiaries to continue having access to telehealth services, we should consider: where does telehealth shine and how do we set pricing for telehealth? After looking through the national data, Aledade's own data from our ACO member practices and conducting discussions with Aledade field teams, we outline the potential spectrum of approaches and put forth a recommendation on pricing policymakers should consider as we look toward the future of telehealth.

Though there might not be consensus on next steps, there is general agreement that we don't want to return to a pre-pandemic world where hardly any Medicare beneficiaries used, or had access to, telehealth. On the other end of the spectrum, many agree that we need to protect against overutilization and acknowledge circumstances where telehealth should not substitute for in-person care.

We've seen that patients, especially those who are relatively healthy and young, value the simplicity of being able to open an app and talk to any doctor to quickly resolve certain issues. For acute conditions like a urinary tract infection or a sore throat the direct-to-consumer telehealth model is reasonable because an established primary care relationship is not required for treatment, especially in younger, healthier populations. However, for many patients who have a chronic condition or other risk factors, it's critical that they have access to telehealth through their primary care provider to build and preserve that relationship.

Market-Level Interviews

Because Aledade works with Medicare providers across 32 different states, we were uniquely positioned to speak with field teams that had firsthand experience with helping independent primary care providers roll out telehealth in the middle of the pandemic. In speaking with them, we found similar themes across the three different Aledade markets that were interviewed (AL, CA, GA).

1. Many practices began offering telehealth out of necessity, not desire (they typically prefer more time to pilot new initiatives before scaling). Most see the value of telehealth for certain services and circumstances, and some noted that as more data comes out from telehealth usage during the pandemic they would like guidance around what patients, services and conditions would be a best fit for telehealth.

2. Even as patients return to in-person visits, many providers and patients prefer to continue transitional care management (TCM) as a virtual service because it allows care coordination for recently hospitalized patients that have a difficult time getting to the provider's office.[1]

3. Many Medicare beneficiaries enjoy going to the doctor's office because it serves as a social outing for them (*an indicator that the health care system could benefit from more innovative strategies to address loneliness and social isolation*).

4. Some physician practices who see the promise of telehealth are being held back by regulatory uncertainty, and would benefit from clear guidance on what flexibilities will become permanent, as well as what they can expect around payment in the future.

5. Connectivity and broadband access is a major issue that needs to be addressed regardless of geographic location. Creating permanent telehealth expansion without consideration for health equity limits the impact any regulation could have on improving health quality and access.

Based on our interviews, we believe it is possible to avoid the telehealth floodgate others have suggested by placing primary care and total cost of care models at the forefront. Existing Medicare beneficiaries and providers continue to prefer in-person visits for a myriad of reasons. Nonetheless, CMS should begin the adoption of telehealth in preparation for a more connected and technologically savvy cohort of patients aging in.

[1] *Number of TCM visits done through telehealth dropped by 33.8 percent compared to a 45.0 percent drop in number of E&M visits done through telehealth March 1—June 1 2020 and the same period in 2021.*

Availability and Pricing of Telehealth

Aledade's recommendations are driven by the belief that primary care providers with established patient relationships are best positioned to coordinate care and contain costs, especially when they participate in total cost of care models such as the Medicare Shared Saving Program. Additionally, we believe there should be safeguards to prevent Medicare beneficiaries from becoming a lucrative patient population for direct-to-consumer telehealth companies, where the payment for providing telehealth to Medicare beneficiaries would be 2 or 3x greater than for commercial patients if Medicare continues to pay parity for all visits.

1. Follow CMS' Proposal for Mental Health

The first option for pricing general telehealth is to follow CMS' proposal for mental telehealth as outlined in the 2022 Proposed Physician Fee Schedule. Following the proposal, providers would be required to see a beneficiary in-person every six months to be able to bill for telehealth services. They would be paid at a similar rate as if the visit was done in person. The advantage of this model is that it focuses on using telehealth to maintain a longitudinal relationship between a beneficiary and their primary care physician, especially for beneficiaries living with multiple chronic diseases. The disadvantage is that it does not provide a mechanism for beneficiaries to utilize telehealth as an occasional convenience or to treat a temporary acute condition.

2. Different Pricing but Available for All Providers

The second option for pricing telehealth is to make telehealth available to all providers, regardless of their relationship with a beneficiary. However, the payment rates for direct-to-consumer companies would be lower than the payment for a practice with a physical location. This option allows beneficiaries the use of telehealth to maintain a relationship with their PCP and for occasional acute conditions, but it also recognizes that physical practices providing some in-person visits have overhead costs not incurred by purely virtual providers. Practices with a physical location should receive rates that are at least 85 percent of the payment amount in the Physician Fee Schedule while purely virtual providers should receive no more than 60 percent of the fee schedule rate.

3. Leveled Reimbursement with G-Code for Established Relationships

This proposal is a simplification of proposal 2 and expands on the model used by many commercial plans where providers are paid a flat fee per visit, regardless of length or complexity (typically $50 to $60). CMS could develop a set of three codes, similar to those used for telephone E&M visits (99441 - 99443), to account for visit time or complexity. These three codes would be available to any provider and paid at a rate of $40-$70. Additionally, a g-code priced at a minimum of $30, should be made available to any provider that has an established, ongoing relationship with the beneficiary. Criteria for defining this relationship could include whether the provider had billed an annual wellness visit (AWV) for that beneficiary in the previous 24 months, seen the beneficiary in person within the last 12 months, provided chronic care management (CCM) services, or if the beneficiary appears on an attribution list for providers participating in alternative payment models (APMs).

4. Same Pricing and Availability for All Providers

The final option for pricing telehealth is to make no distinction between provider type or the relationship with the beneficiary. This would allow any provider, regardless of whether they exclusively offered telehealth services or had a brick-and-mortar practice, to offer telehealth services and receive the same rate. Additionally, it would allow these services to be billed for any beneficiary whether they had an in-person visit or not. We consider this to be the most open, and most expensive, payment model for Medicare to implement. It could also potentially jeopardize preserving or building the longitudinal primary care relationship for Medicare beneficiaries and could lead to more fragmented care in this population.

Aledade's Recommended Payment Model

To account for the need to have a hybrid model where providers can offer both in-person services and telehealth services, it is important to separate providers by the type of telehealth business model they participate in and set payments accordingly. On one side, you have the direct-to-consumer services where the billing TIN primarily bills telehealth. These are the apps patients open when they have a non-severe acute illness and just need to see a doctor fast. On the other side, you have a business with a brick-and-mortar location and an established patient panel that typically sees their patients in-person but expanded telehealth services during the pandemic and would like to continue offering them.

Providers who fall in the first category should be paid at a lower rate than the brick-and-mortar provider, because they are able to minimize their overhead and improve their efficiency, since telehealth is all they do. Their model is mostly based on providing convenient care options for people who do not have a primary care relationship and are looking for care for non-complex acute conditions. They don't need a large office space with a waiting room, multiple consult rooms and complex equipment. They also employ less staff per visit than a typical primary care provider that might have a care management team. Overall, their fixed expenses are substantially lower.

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Hybrid providers on the other hand have the same fixed costs whether they see 10 patients or 25 patients in one day. They offer telehealth as a way to enhance the relationship with their patients and provide

high quality care in a more accessible setting, but it is not their "bread and butter." Any pricing policy that does not account for the reality that patients will be switching back and forth in this hybrid model risks siloing physicians who either exclusively do telehealth or exclusively see patients in person.

The simplest solution to pricing telehealth within Medicare is to have a limited set of codes with an additional payment for providers who have established patient relationships (option 3). This is critical if we want to continue to transition to a value-based care system. In a value-based care model, integrating telehealth can help ensure that primary care practices can have hybrid models of care, seeing patients both in person and virtually, while making sure that the primary care relationship can continue and thrive. In discussing telehealth with some of the practices Aledade works with, we found out that certain visits, such as transitional care management visits, work really well for some patients. Telehealth has also helped some family caregivers feel they have better access to information on a family member's condition. Still, as some look ahead to the future of telehealth, there will likely be temptation to impose traditional fee-for-service utilization management on telehealth, including limitations on number, type and setting of telehealth visits covered, lower payment for telehealth visits, cost-sharing for patients, payment only for "high value" tele-visits and identifying providers who are tele-visit utilization "outliers." These approaches run counter to getting more value in the healthcare system.

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