Virtual Health:
Long-term Strategies for Employed Physician Networks

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Presenters

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Expertise in:
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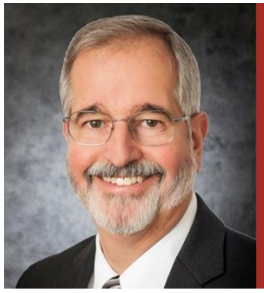

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32+ Years in Healthcare Management & Consulting

Expertise in:
Revenue Cycle Management
Compliance
Credentialing
Coding, billing, and related documentation – including telehealth

Objectives

1. Understand the benefits of systematically incorporating virtual care in practice care delivery models.
2. Recognize that provider scheduling, compensation, and staffing norms may change.
3. Identify strategies based on the anticipated future regulatory, reimbursement, and patient care environments.

Builds on the basics of our April 2, 2020 webinar – Virtual Visits: Reimbursement and Operational Logistics

https://hsgadvisors.com/performance-improvement/virtual-visits-collecting-fees-and-operational-logistics/

Virtual Health – Background

- A form of remote telehealth delivery in which patient-provider interactions occur through telecommunications technology
  - Synchronous – Interaction occurs in real time
    - Video teleconferencing
    - Telephone
  - Asynchronous – Interactions have time lags between responses
    - Patient portal messaging
    - Secure email messaging
    - Secure text messaging

Virtual Health – Background

- Benefits
  - Patients
    - Greater convenience
      - Timing, Travel
    - Greater access – primary and specialty care
    - Lower costs (perhaps)
  - Providers
    - Greater convenience
    - More flexible scheduling/time management
    - Improved access to patients
      - Removes transportation barrier
    - Greater access to consultants
  - Administration
    - Decreased cost of care
    - Increased operational efficiency

Virtual Health – Background

- Historic barriers to expanding concept
  - Reimbursement in fee-for-service environment
    - Varies by payer
  - Patient acceptance
  - Provider acceptance
  - Secure mechanism that protects patient privacy
    - Even pre-HIPAA
  - Availability of technology
    - For both provider and patient
  - Facile use of technological capabilities
    - For both provider and patient

Virtual Health – Background

- Suddenly exploded with COVID-19 Public Health Emergency (PHE)
  - Social distancing
  - Canceling elective face-to-face encounters
  - Conserving resources (PPE)
  - Relaxation of regulatory restrictions
  - Payment in fee-for-service manner
- Catalyzed by significant CMS (and other insurer) regulatory waivers and reimbursement changes
- Accompanied by significant provider and patient "acceptance"
  - Perhaps born out of circumstantial necessity

Virtual Health – Background

- Most feel that telehealth interactions will continue to be more prevalent than before COVID-19
- The questions become …

What does the future hold for our virtual care initiatives?

What can we look forward to after the COVID-19 PHE?

Virtual Health – What We Know

- **The types of "virtual visits" codified by the 2019 and 2020 Medicare Physician Fee Schedule Final Rules will continue to be recognized and reimbursed by Medicare FFS**
  - Notably -- CMS does not consider them to be "telehealth"
  - Includes
    - Virtual Check-ins
    - E-Visits (via patient portal)
    - "Store and Forward" Communication (images and videos)
    - Interprofessional Internet Consultation
    - Chronic Care Remote Physiologic Monitoring
    - Self-measured BP Treatment Plan Support
  - Receive wRVU credit and payment for previously unreimbursed "indirect" patient-related interactions
    - Rates less than office visits
      - Less overhead
      - Not all payers had previously adopted

Virtual Health – What We Know

Interaction	E&M Code	Ave. Payment	wRVU Credit	Provider Time
Office Visit	99211	$23.46	0.17	5 min or N/A
	99212	$46.19	0.45	10 min
	99213	$76.15	0.67	15 min
Virtual Check-in	G2012	$14.80	0.25	5-10 min
E Visit	99421	$15.52	0.25	5-10 min
	99422	$31.04	0.50	11-20 min
	99423	$50.16	0.80	> 21 min
Store & Forward	G2010	$12.27	0.18	5-10 min
Self BP Monitoring	99474	$15.16	0.18	N/A

Virtual Health – What We Know

- Many practices had not known of nor incorporated into daily operations prior to COVID-19 PHE
- Opportunity to standardize and streamline processes associated with these interactions
  - Define standard processes for these interactions that fulfill requirements
    - Ensure all providers and support staff are aware of requirements
  - Ensure provider-patient interaction occurs
    - Cannot fully delegate interaction to support staff
    - … but support staff can make them more efficiently rendered
      - Obtain background information
      - Arrange for specific time for synchronous interactions … and connect for provider
  - Standardize documentation and billing procedures
    - Consider templated formats in EMR to assist documentation compliance
    - Build to withstand audit

Virtual Health – What We Know

- Opportunity to standardize and streamline processes associated with these interactions (continued)
  - Determine whether provider scheduling processes should be modified
    - Conduct outside of normal business hours *– versus –*
    - Schedule blocks of time to address (e.g., at end of morning and afternoon) *– versus –*
    - Schedule time per office hour (e.g., "blank appointment" 10 minutes each hour to address virtual visits)
  - Determine if practices will embark on or partner with vendors supporting interfaceable home monitoring devices and processes
    - e.g., Glucose, BP, daily weight monitoring

Virtual Health – What We Know

- **Other "telehealth" interactions**
  - CMS' original telehealth regulations consistent with traditional telemedicine delivery
    - Limited to designated rural locations
      - CMS expanded to all locations of care during COVID-19 PHE
        - Popular support for future regulatory change to include all locations of care
    - Originating site (patient location) must be within a healthcare facility
      - CMS permitted patient location to be "home" during COVID-19 PHE
        - Popular support for future regulatory change to permit virtual care in homes
        - Permits greater patient convenience and assists with transportation issues
    - Distant site (rendering provider location) provider must be licensed in the originating site state and possess clinical privileges in originating site facility
      - CMS COVID-19 PHE waivers included permission to provide care in states in which provider not licensed to maximize healthcare resources
      - CMS ultimately indicated using office POS for telehealth – even if provider at home when rendering care
        - Popular support for future regulatory change requiring licensure and credentialing only at distant site – i.e., where provider located and where care would be rendered if not via telehealth/virtual care (prior efforts rebuked)

Virtual Health – What We Know

- **Other "telehealth" interactions** (continued)
  - CMS' original telehealth regulations consistent with traditional telemedicine delivery (continued)
    - Permissible interactions
      - CMS expanded the list of permissible patient encounters during COVID-19 PHE
        - Covering most face-to-face encounters during PHE
        - Added telephone encounters to reimbursable interaction list
          - Late addition to list based on "persistent" provider requests
          - 99441 – Patient initiated telephone evaluation and management service provided by a physician/credentialed provider to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
          - 99442 – 11-20 minutes of medical discussion
          - 99443 – 21-30 minutes of medical discussion
          - During the PHE, CMS equated the 99441 to a 99212; the 99442 to a 99213; and the 99443 to a 99214
          - Distinction re: Virtual Check-in – 5-10 minutes, can respond by any mechanism, more poorly reimbursed
        - Not expected to persist after PHE lifted – though tremendous popular support for reimbursing all patient interactions if delivered via telehealth/ virtual care mechanism to accelerate full incorporation into routine patient care interactions

Virtual Health – What We Know

- **Other "telehealth" interactions** (continued)
  - CMS' original telehealth regulations consistent with traditional telemedicine delivery (continued)
    - Reimbursement rates
      - CMS reimbursing telehealth interactions at in-person rates during COVID-19 PHE
        - Not expected to persist after PHE lifted – though tremendous popular support for continuing
        - Many providers continue to question "If not, why just not schedule an office visit then? Greater reimbursement and wRVU credit for same time (provider)."
    - Telecommunications technology must conform with HIPAA requirements
      - CMS waived these requirements – especially for video connectivity – during COVID-19 PHE
        - Secure communications that ensure HIPAA compliance likely to be required post-PHE
          - Not likely to be able to use Zoom, et al, over long term
      - Explore post-COVID-19 options now
        - EMR versus separate platform and BAA for video interactions
        - Patient portal maximization for secure messaging (if not currently enabled)

Virtual Health – What We Know

- **Other "telehealth" interactions** (continued)
  - CMS' original telehealth regulations consistent with traditional telemedicine delivery (continued)
    - Medicare co-pays and deductibles apply to virtual health encounters
      - CMS permitted provider discretion to reduce or waive these fees if desired during the COVID-19 PHE
        - Anticipated that CMS will return to co-pay and deductible applications after COVID-19 PHE lifted, which providers cite as potential patient barrier to acceptance
    - Intended to be for "established" patients only
      - CMS indicated that HHS would not audit process to determine whether used for "new" patients – and ultimately endorsed using for all patients for whom virtual care was appropriate
        - Anticipated that CMS will return to "established" patient designation after COVID-19 PHE lifted

Virtual Health – What if …

- What if CMS, Medicaid, and commercial insurers yielded to provider and public pressures to revise regulations/parameters for office-based virtual care to permit …
  - Application to all practice locations – not just rural designated areas
  - Patients can be at home or at work during virtual interactions – and not in a healthcare facility
  - Providers to be considered in the office when providing virtual care
    - Office point of service eliminates need for licensure and clinical privileging where patient is physically located and allows provider to remotely offer service
  - Utilization for all types of patient interactions permitted during the COVID-19 PHE
  - Reimbursement at same rates – or minimally discounted rates – as in-office encounters
    - Balance decreased overhead related to space and utilities yet account for provider and support staff time
      - Anticipates utilizing support staff to efficiently manage virtual care for both patients and providers

Virtual Health – What if …

- Should remove many barriers to continue incorporating virtual care into daily office practice after the COVID-15 PHE is lifted
  - Even if the requirements for HIPAA compliance, co-pays and deductibles, and applicability to "established" patients only still apply
- Remaining barriers include
  - Provider acceptance
    - Still hear of physicians who refer to telehealth interactions as temporary and inferior to in-person encounters
    - However, majority seem to embrace – especially for certain types of interactions
  - Patient acceptance
    - Still hear of patients who refer to telehealth interactions as temporary and less acceptable than in-person encounters
    - However, majority seem to embrace – especially for certain types of interactions

Virtual Health – What if …

- Remaining barriers include
  - Technology
    - HIPAA compliant telecommunications pathways
    - Interfaceable patient monitoring connectivity
    - Internet speeds
    - Patient portal expansion/utilization

Virtual Health – What if …

- Clinical Operations – Care Delivery Model
  - How should we best incorporate virtual care into daily clinical operations?
  - What operational processes should be created or modified to ensure maximum use of virtual care to enhance patient-centric patient access to care?
  - How can virtual care augment patient care for minor acute care, sub-acute care, and chronic care so that patient needs can be anticipated and met in the most convenient manner?
    - How should the practice alter scheduling for both providers and clinical support staff to maximize extent and efficiency of virtual and in-office care?
    - How can the practice utilize interfaceable monitoring capabilities rather than manual devices to permit greater patient and provider/support staff conveniences? Eliminates manually recording, bringing/sending data then manually documenting, reviewing, and entering associated data in the medical record.
  - How can individual talents be best utilized?

Virtual Health – What if …

- Clinical Operations – Care Delivery Model
  - How can we maximize acceptability of virtual care for all?
    - Define the acceptable types of interactions and the associated requirements
    - Treat the interactions as if the care is being rendered in person
      - Choose interactions wisely and appropriately to best utilize time and effort
      - Be prepared
      - Smile – even if no one can see you – as it can be portrayed in your voice inflections
      - Engage the patient directly
      - Be present and attentive in the interaction
      - Keep educational explanations brief – break into digestible pieces and split into successive, briefer interactions
      - Determine and convey agreeable follow up plans and/or instructions
      - Repeat back verification becomes even more important
    - Ensure all staff are on the same page with a standardized approach and common understanding

Virtual Health – What if …

- Business Operations
  - Will the practice confine itself to virtual care that is reimbursable by third party payers?
  - Will the practice implement virtual acute care for a flat rate – similar to the commercially available companies that offer these services?
  - How will co-pays and deductibles be collected?
    - Credit card at interaction or delayed billing?
  - Documentation, billing, and coding
    - Develop EMR templates to assist with encounter note completion and documentation compliance
    - Develop coding educational program and point of care aids
    - Ensure effective bidirectional communication and feedback between office staff, providers, and revenue cycle staff
  - Marketing
    - Within practices – signage, staff interactions with patients
    - External to differentiate in market

Virtual Health – What if …

- Business Operations
  - Explore options for reimbursement with commercial insurers
    - Determine business models required to maximize success with increasing levels of risk contracting – bending the cost curve and moving toward full risk capitation
  - Anticipate potential impact of virtual care emphasis on provider compensation model
    - Are special considerations required?
    - Is model revision required?
  - What is the budgetary impact?
  - What is the strategic planning impact?

Virtual health – Resources

- CMS Telemedicine Toolkit
  - Available at https://www.cms.gov/files/document/general-telemedicine-toolkit.pdf
  - Collection of resources from multiple sources covering basics, vendors, technical assistance, and CMS policy
    - Special sections related to COVID-19
- Telehealth.HHS.Gov
  - Available at https://telehealth.hhs.gov/
  - Provides information for both patients and providers
  - Provider sections cover elements such as
    - Getting Started
    - Planning Workflow
    - Preparing Patients
    - Billing and Reimbursement
    - Legal Considerations
    - Other reference materials
  - Links to multiple sources

Virtual health – Resources

- AMA Telehealth Implementation Playbook
  - Available at https://www.ama-assn.org/system/files/2020-04/ama-telehealth-playbook.pdf
  - Provides extensive guidance for developing telehealth programs from start to finish – including evaluating success
  - Offers forms and other resources for consideration

Virtual Health

- Conclusions
  - Virtual visits offer longer term care delivery alternatives to
    - Provide needed patient care through a mutually convenient, secure mechanism
    - Expand access to practice services
    - Expand access to patients
    - Engage patients in a manner that is most acceptable to them
    - Safely deliver care in the most cost effective manner
    - Prepare for full risk contracting


HSG | Questions

Upcoming Webinar

Advanced Practice Providers: Employment, Compensation, and Utilization Models

Thursday June 25th, 2020 – 2:00pm EDT

Register Here

Webinar Description

Health systems have been hiring Advanced Practice Providers (APPs) for many years. However, the traditional model of offering "at will" employment and straight salary compensation has not proven beneficial as the health care environment evolves. Similarly, hiring APPs as a strategy to fill gaps in care delivery caused by recruitment difficulties does not bear fruit unless the APPs can be effectively assimilated into the organization's culture and care delivery models in a manner that permits reliable, top of license usage. Employment, compensation, and utilization strategies and tactics are just as important for APPs as they are for physicians – but many health systems do not approach them in the same way.

This webinar will explore effective APP employment vehicles, address comprehensive APP compensation models, and promote effective APP utilization.

Learning Objectives

1. Understand the benefits of APP employment contracts.
2. Recognize the need to align APP compensation with same-specialty physicians and the organizational goals and objectives.
3. Focus on adjusting care delivery models to maximize the APP's talents and capabilities.

Presenters

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Company **Overview**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Headquarters: Louisville, KY

Formed: 1999

Focus: Health Systems and Physician Network Strategy and Execution

Physician Strategy

Driving a common strategic focus with engaged physicians.

Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

Performance Improvement

Improving the performance of employed physician networks.

Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

Physician Compensation

Aligning physician compensation with health system and employed network goals.

HSG **Services**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

Physician Strategy

- Healthcare System Strategic Plans
- Employed Physician Network Strategy
- Growth Strategy
- Shared Vision and Culture Development
- Physician Manpower Plans
- Service Line Strategy
- Co-Management

Physician Leadership

- Shared Vision and Culture
- Physician Burnout
- Physician Governance and Leadership

Performance Improvement

- Network Performance Improvement
- Performance Improvement Implementation
- Network Revenue Cycle
- Practice Care Model Transformation
- Practice Acquisition
- Advanced Practice (APP) Utilization
- Virtual Health

Network Integrity

- Patient Share of Care
- Patient Flow
- Provider Location and Service Analysis
- Market Insights

Physician Compensation

- Compensation Plan Design
- Fair Market Value and Commercial Reasonableness Opinions
- Advanced Practice Provider (APP) Compensation

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12 Years at HSG
23 Years in the Industry

Strengths

- Employed physician network management
- Physician network assessment and optimization
- Physician alignment and engagement
- Network executive recruitment and contracting

Client Accomplishments

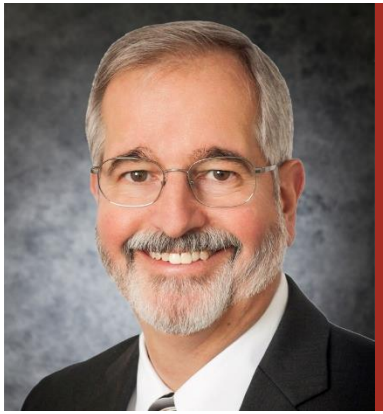
- Improved quarterly collections for client's employed physician network by $1.7 million

PROFESSIONAL EXPERIENCE

Mr. Creech's practice focuses on appropriately assessing the needs of employed physician networks, identifying opportunities to enhance the performance and culture of these networks and developing a strategic vision for the future for these networks to become an asset for the organization. His firmly-held belief is that HSG develops partnerships that benefit clients by having consistent advice from advisors who understand the market and knows the key players. He uses the phrase "The HSG Experience" to describe success provided to partner clients.

EDUCATION

Davis was an executive at Jewish Hospital for 7 years with leadership roles in Physician Management, Network Referral and Development. He holds Masters' degrees in Business and Hospital Administration from Xavier University and a Bachelors Degree in Economics and Management from Centre College.



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6 Years at HSG
36 Years in the Industry

Strengths

- Shared vision and strategic planning
- Physician alignment and engagement
- Physician leadership structure
- Development of clinical operations, assessments, and transformation

Client Accomplishments

- Worked with client executives and physicians to create shared visions that led to significant advances in network function and outcomes

PROFESSIONAL EXPERIENCE

After retiring from Naval service, Dr. McWilliams spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, a non-teaching community hospital within a larger academic health system. As CMO, he supervised the Medical Staff Services Office and was additionally responsible for quality of care/patient safety/risk management, clinical information systems, physician recruitment and clinical service line development. At the system level, he was intimately involved in creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

EDUCATION

Terry received his MD from the University of Pittsburgh School of Medicine and completed family medicine residency in the Navy. He completed a Master of Science in Jurisprudence (MSJ) in Hospital and Health Law from Seton Hall University School of Law.