Driving telehealth in the new normal using data & analytics

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Telehealth, in general, and telemedicine and telemonitoring, specifically, have been growing substantially over the prior decade, but they have exploded over the last three months as the worldwide COVID-19 pandemic forced millions to stay at home for extended periods. Historically, physician acceptance has held back telehealth, in part because of low reimbursement, but also in the face of a belief that it would be difficult to render care effectively. Experts agree that only certain types of care are appropriate for Telehealth. Similarly, many patients felt it would not offer the same level of interaction and diagnosis they were accustomed to receiving.

However, in the face of the COVID-19 pandemic and the changes it has engendered, such barriers are fast disappearing. In addition, with the changes in virtual care delivery coverage for Medicare patients put in place by the Centers for Medicare and Medicaid Services (CMS), the concerns about reimbursement have faded into the background. With Medicare on board, private commercial insurers were quick to follow. Use of telehealth services surged as numerous states waived prior restrictions on the services and, presented with no realistic alternative, health care providers moved to virtual platforms as a way of managing care for their patients.

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This highlighted the efficiencies and effectiveness of telemedicine, even to the most ardent skeptics. Some providers believe most of what they once did through on-site office visits can be done with telemedicine. Numerous physicians on the front lines of care delivery now believe that telemedicine must be incorporated into their practices as care delivery will NOT return to the old methods once the pandemic fades.

In many ways, CMS started the trend and has continued to provide substantial relief related to telehealth. First, it sharply expanded the number of services for which telemedicine was allowed and authorized providers licensed in one state to provide services to patients in another under a Section 1135 waiver. Under this waiver, Medicare agreed to pay for office, hospital, and other visits furnished via telehealth starting March 6th. Then, on March 22nd, CMS announced relief for clinicians, providers, hospitals and facilities participating in Medicare quality reporting (QRP) and value-based purchasing (VBP) programs. CMS emphasized “people over programs. CMS emphasized "people over programs. CMS emphasized "people over programs. CMS emphasized "people over programs." CMS also announced that it would use prior year quality measure results for 2020 reporting. CMS continued relief efforts when, on March 30th, it suspended RADV activities related to payment year 2015 audits and stated it would not initiate any additional contract-level audits until after the public health emergency has ended. Most recently, on April 13th, CMS announced the postponement of the 2019 benefit year HHS Risk Adjustment Data Validation (HHS-RADV) process.

During the height of the pandemic, physician office visit volumes, even with telemedicine allowed in virtually every situation possible, declined as much as forty percent across the country. Patient visits are starting to ramp up as physician offices reopen, but this only marks the beginning of a “new” normal. Providers are recalling furloughed staff, implementing longer business hours to accommodate cleaning between patients, staggering work days for clinicians, and determining which patients are most appropriate for in-office or telehealth. Patient fear notwithstanding, everyone recognizes that the volume of office visits will not return to the pre-pandemic rates quickly.

A number of provider groups, along with some politicians, have called on CMS to make most, if not all, of the changes permanent. Some worry that these are temporary measures, but CMS Administrator Seema Verma stated recently “You’ll see that some of the provisions that we have extended on a temporary basis will be made permanent.” NCQA has explained it will publish guidance on July 1st for its updated telehealth guidance in 40 HEDIS measures, as well as align the measures with CMS and other stakeholders which confirms the long term viability of telehealth.

The Role of Analytics

Claims data from April and May clearly confirms the widespread adoption of telehealth. We believe that is just the tip of the iceberg. While federal agencies, public payers, and large commercial insurers alike have expanded access to telehealth amid the pandemic, many struggle with ensuring telehealth is being applied to the right patients for the right healthcare needs while increasing efficacy and efficiency in care delivery. In that light, we see great promise in analytics and machine learning as care delivery adapts to a world with extensive use of telehealth. Data driven analytics are a key component of ensuring efficacy and efficiency of Telehealth.

Choosing the right virtual model

Plans and providers must select a model that suits both providers and patients. Examples include:

• On-demand virtual urgent care, as an alternative to lower acuity emergency department (ED) visits, urgent care visits, and after-hours consultations, is a huge opportunity for telemedicine. Analytics can help identify the best patients target for outreach.

• Virtual office visits for services that do not require physical exams or concurrent procedures with a patient’s established provider is also an easy provider efficiency and patient satisfaction “win”.

• Near-virtual office visits can extend convenient patient access to care outside a provider’s office, combining virtual access to physician consults with in home testing or “near home” sites, such as worksite clinics or retail clinics, for testing and immunizations.

• Virtual home health services can also greatly expand in home care, which is widely recognized as beneficial to the patient’s long-term mental and physical health. These services employ virtual visits, remote monitoring, and digital patient engagement tools to deliver significantly more services remotely, and can include portions of an evaluation, patient and care giver education, physical therapy, occupational therapy, and speech therapy.

• Tech-enabled home medication administration can shift even more infusable and injectable drugs from the clinic to the home.
Medical management, patient safety and satisfaction

As we know, the impact of COVID in short term is broader than risks posed by the infection itself. Measures such as stay at home, social distancing, and remote work and school, combined with the personal safety concerns, have led many people to defer both elective procedures as well as routine, preventative, and chronic care. Regrettably, the progression of chronic diseases such as cancer, heart disease, and dementia do not recognize a pandemic as a reason to pause. Unfortunately, delayed treatment due to either the fear or inability to visit a physician’s office or emergency room during the pandemic can lead to a rapid and irreversible deterioration of health. The unprecedented unemployment also poses significant risks for large segments of the population as care becomes less affordable. Finally, while all populations are impacted, the aged and those with comorbid conditions (such as heart failure and lung disease) face even greater risk.

For health plans to manage populations post COVID-19 while maintaining, if not improving cost, quality, and utilization trends, strengthening telehealth through Medical Management initiatives is absolutely critical. Medical management teams need to collaborate with providers to apply the best telehealth or in person option to engage the right members with appropriate care at the right time.

Data analysis of each member’s history and diagnoses can identify members with medical need or high risk if exposed to COVID-19 for whom telehealth is the last best option to ensure quality of care. A 360-degree view of the member, created from medical and pharmacy claims as well as social determinants of health, enables focused identification as well as stratification based on impact on outcome of the right population for telehealth. By stratifying members in this manner, health plans can help providers focus their limited resources on the right population. Another benefit of telehealth is increased patient experience and satisfaction. Early data is incredibly encouraging. Combined with its ability to address patient safety concerns, telehealth is fast becoming a preferred option for continuity of care among large groups of members. This increased patient willingness to engage in telehealth offers options for new initiatives and performance improvement. Strategic focus on Telehealth related benefit design, network deployment, and promoting care continuity are substantial opportunities for plans to impact stars ratings, HEDIS scores and other measures and take leadership in the evolving healthcare market. Health plans that take a leadership role in identifying the right members for the right care across various telehealth options will be better positioned than their peers.

Telehealth’s impact on risk adjustment and quality

As noted, CMS has issued various directives that resulted in historic expansion of telehealth, and this has had a material impact on the Medicare risk adjustment structure. CMS’s 1135 waiver allowed Medicare to pay for office, hospital, and other visits furnished via telehealth. In addition, CMS’s April 10th guidance allowed all Medicare Advantage, Cost, PACE, and Demonstration Organizations to submit diagnoses for risk adjusted payment for telehealth visits. These changes are key to allowing providers to continue to treat high-risk members, and payers to accurately represent their acuity and quality of care rendered.

The regulatory changes, which came rapid fire, were too numerous and difficult to stay on top of for most healthcare coding personnel. More than 90 changes were made to the codes used to bill for telehealth visits.

In some cases, private insurance companies posted reimbursement guidance that was in direct conflict with CMS directives. Many healthcare organizations paused billing and coding systems in an effort to allow the rapidly changing regulations to reach some equilibrium. Most troubling, organizations that were quickly able to pivot to delivering telehealth as well as those that were not, are still awaiting guidance on how long the rushed regulatory changes will be in place.

Moving forward, it is critical that the industry learn from the telehealth experience and build upon best practices for the future. There are several ways technology play a significant role in how telehealth visits support risk adjustment.

These include:

- Identify the patients that would most benefit from a telehealth visit — e.g., their condition can be safely and accurately assessed using telehealth versus those patients that must be managed through a face-to-face visit.
- Stratify patients to determine those that have the most urgent need to be scheduled for a visit - either because they are particularly vulnerable and at risk of deterioration or are good candidates for following up on preventive or elective procedures.
- Provider organizations need good analytic tools that enable them to adjust these criteria as the world normalizes.
- Prepare for additional outbreaks ‘waves’ during the return to normal process. Offices and facilities may need to deal with surges in patients that could put their current processes at risk of additional shutdowns or changes. Analytics can flag emerging warning signals.
- Measure the impact of telehealth on patient outcomes and shifting reimbursement rules to determine which are appropriate in a sustainable ongoing program.

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Long-term strategy
In the post-pandemic world, telehealth as a healthcare delivery mechanism is here to stay. A data-driven analytical approach, employing certain key components, will ensure success of a value-based Telehealth strategy.

Embedding Telehealth in Product/Plan Design
Telehealth can help meet changing consumer preferences and demands for lower-cost plans. Inclusion of virtual-first networks, digital front-door features (for example, e-fragile), seamless “plug and play” capabilities to offer innovative digital solutions, and benefit coverage for at-home diagnostic kits will both reduce costs and increase patient satisfaction.

Measuring Outcomes and ROI
It is critical to measure the value that stems from such changes, not just from a cost, but also from a clinical quality, optimized utilization, and a patient/provider satisfaction perspective.

Operational Analytics, Managing Volume Influx
Improved insight will allow providers to deliver better, faster, and more meaningful service to patients, improve quality, as well as find efficiencies in their own operations. Key performance indicators include overall volume, peak usage times, average call length and wait times, diagnoses/reasons for visit, revenue volumes and ratios, and prescription rates.

Keeping up with the regulatory framework
The types of services that are possible have expanded significantly over the past several years, but even more so during the pandemic. This will mean being cognizant of the regulatory environment, and identifying and correcting potential coding errors during the changing regulatory guidance to ensure optimal program performance. Sensitivity here will enable improved performance in Medical Management as well as Quality Programs and Risk Adjustment solutions.

Reimbursement Strategy
Driving long-term behavior change requires that health plans offer optimized reimbursement structures for providers. While COVID has accelerated telehealth adoption, for momentum to continue, payers must incentivize providers to use telehealth to transform and then monitor payment accuracy to ensure effective capture of affordability improvements. Analytics can provide trend and outcome data that can assist in creating permanent reimbursement and best practices for telehealth-related patient visits. Ultimately, if applied appropriately and within regulatory structures, telehealth can add substantial value to an effective risk adjustment solution.

Telehealth requires Evolution of Traditional Payment Integrity Operations
With significant changes in healthcare, payment integrity plays a crucial role in ensuring affordability. Most payment integrity operations are built around a typical face-to-face encounter with supporting medical records and related facility/office/clinic information. Telehealth encounters, however, produce different types and volumes of information, creating a unique challenge from an audit perspective. Just as legacy claim systems were designed to support a fee for service payment model and struggle as the landscape transitions to value-based care, traditional cost containment operations were designed around face-to-face interactions with significant amounts of supporting documentation and will struggle to address telehealth services.

Payers will need to develop clear and comprehensive policies governing telehealth services. These policies, in conjunction with CMS guidance and regulations, will form the foundation for monitoring and ensuring the accuracy of telehealth services. This process has begun but in these unprecedented times, there is need to proceed at “Warp Speed”. Payers will also need to rethink and enhance their cost containment operations to detect inaccuracies and irregularities in telehealth billing. Excess utilization, over coding and unbundling of services will all have to be examined in a new light to determine how best to identify issues unique to telehealth.

There is also an immediate risk of an increase in fraud and abuse due to the amorphous nature of what should be payable as telehealth services. The most unscrupulous providers will simply bill for services they do not even provide – and create fake documents to “support” it. Some providers will bill a telemedicine visit for things they do – such as answer patients’ questions on the phone - when in fact that has part of their overall ongoing care of the patient for years, and is not truly the type of service telehealth is designed to cover. Similarly, some remote monitoring – which many hospitals instituted for patients at risk for COVID-19, but not serious enough to justify inpatient care or even outpatient observation – are simple things that can now be done with readily available technology, some even on ubiquitous smartphones. This could mean an explosion of new claims for telemonitoring. Of course, more traditional schemes are also possible - when billing for telehealth, providers classify the care into one of three tiers, depending on the level of care delivered. There may be a bias for some practitioners to over-code their telehealth interactions to get the highest level of reimbursement.

It is undeniable that COVID-19 has changed the world in significant ways. It has created fear and disrupted the lives of millions, and it is not clear that we will ever truly return to our prior existence. If anything, one possible silver lining is the promise of telehealth to deliver cost effective, high quality care that patients value.

Of course, there is work to do to get there.
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