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Booming telehealth use is transforming health care delivery, including CMM, but what happens post-pandemic?

We've watched telehealth gain ground over the last few years, but none of that compares to the spike in the last few months. Driven by the necessity of social distancing—and a loosening of regulations—telehealth is becoming the default method of contact for non-urgent encounters. And it's proving to be a viable approach for comprehensive medication management (CMM).

But will it last?

Telehealth and other virtual care services have allowed providers to maintain their connection to patients as they balance social distancing with the need to continue delivering care.

Unsurprisingly, the growth in telehealth utilization across the U.S. has skyrocketed during the pandemic. Jared Augenstein, a director with Manatt Health, offers a few examples comparing pre-COVID utilization to current numbers:

- **Medicare:** From use by 11,000 member visits per week to more than 1.3 million per week
- **Commercial Plans:** More than 4,000% year-over-year increase in telehealth volume
- **NYU Langone Health:** From 50 virtual visits per day to 5,500 per day
- **Mass General:** A 10 to 20-fold increase

Augenstein expects the pre-COVID trend toward increased opportunities for telehealth to continue although some of the COVID-specific changes will be rolled back.

DEFINITION OF CMM

The standard of care that ensures each patient's medications (whether they are prescription, nonprescription, alternative, traditional, vitamins or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken and able to be taken by the patient as intended.[1]

[1] McInnis, Terry, et al., editors. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* 2nd ed., Patient-Centered Primary Care Collaborative, *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* PCPCC Medication Management Task Force collaborative document

Meanwhile, we're seeing telehealth transform care delivery, including in CMM.

Different modality, same process

Delivering CMM via telehealth doesn't differ all that much from providing it in person, explains Melissa Badowski, Pharm.D., MPH, clinical associate professor of pharmacotherapy at the University of Illinois at Chicago, College of Pharmacy. Regardless of the mode of delivery, CMM follows a 10-step process. (See Figure 1.)

If anything, telehealth may actually enhance CMM delivery, she says. "That's something that we've seen patients really enjoy: the expansion, the access, the flexibility of these visits. It's quicker. Patients aren't in that waiting room anymore. While there is a virtual waiting room, wait times are a lot shorter."

Badowski's interprofessional teamwork uses a video setup that allows everyone on the visit to see each other—and to have the same view as the patient. Figure 2 (next page) shows the screen everyone on the call sees.

Her team typically includes a physician, a clinical pharmacist, a nurse, the patient and a case manager who also plays a vital role in ensuring access to insurance and may be handling some social issues. Other team members and trainees may participate, depending on the situation.

"So, essentially, I get to see every single patient in real time as a part of an interdisciplinary team," she says. "As the clinical pharmacist in this model, I am able to engage with the patient and provide comprehensive medication management."

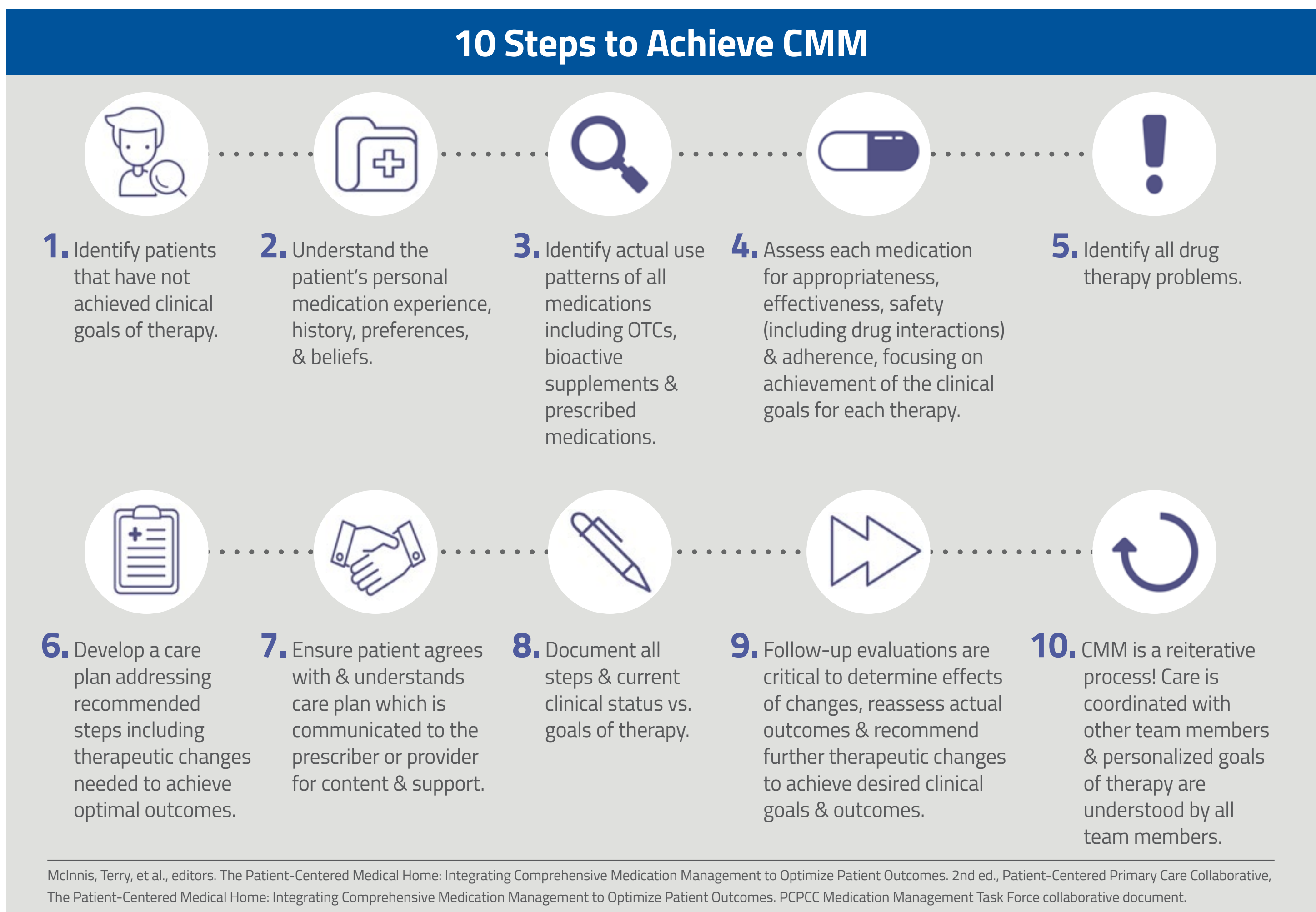

Figure 1

This approach may be even better than the traditional visit.

"Ordinarily, if I were in my own silo providing care for a patient behind a closed door, I might not be aware of some of the social issues the patient is undergoing." The same holds true for the physician. This way, everyone has the complete picture.

Reimbursement isn't a problem—at least not in her model. "We're doing it in real time, so we do have that physician present," she explains. But as long as the patient sees the prescriber the same day or the prescriber is available for an immediate consult, it still constitutes "incident to," she says, and CMS will pay.

"Virtually any patient can engage in CMM through telehealth, assuming they have the necessary technology." But that's the catch.

Telehealth isn't available to all

Some patients are in vital need of CMM but don't have access to the technology. In a recent survey by the Primary Care Collaborative, 72% of the providers who responded reported they have patients who are unable to access telehealth due to lack of a computer/internet.[2]

"So right now, by using telephones, we have been able to expand some of what we're able to do, but I think really having that face-to-face connection is essential; then we can also see what's in a patient's home, their medications and stuff like that. I think it's really important to consider that."

[2] Primary Care Collaborative: Primary Care & COVID-19: Week 4 Survey

Figure 2

So what are these changes that are opening the doors to telehealth services? Augenstein broke them down by payor type.

Medicare: Big changes, some permanent

Historically, Medicare coverage for telehealth has been extremely limited, focusing only on providing access to beneficiaries in rural areas. Medicare had already begun to relax these restrictions for ACOs in Medicare Advantage and for certain narrow services.

Medicare considers telehealth services two different ways, Augenstein explains: traditional telehealth services and virtual check-ins.

Traditional telehealth services are services that would normally be delivered in person but instead are conducted via telecommunication technology. Pre-pandemic, coverage was limited. Services would typically be available only to beneficiaries in rural areas, and in most cases, the beneficiary would need to be in a provider's office, not at home. Services could not be delivered via phone—even via smart phone. Practitioners could only provide a narrow range of Evaluation & Management (E&M) or mental health services.

What's changed? Telehealth is now no longer limited to rural areas. In addition, beneficiaries can receive services at home. CMS is even allowing for certain services to be provided via audio only, given significant numbers of patients lack the necessary technology.

Overall, CMS has significantly expanded the range of covered services and its list of eligible providers. For example, included now are physical therapists, speech pathologists, occupational therapists and other types of providers (but not pharmacists). For a before-and-after comparison, see Figure 3 (next page.)

Issue	Traditional Rule	New Rule During the COVID-19 Pandemic
Patients eligible for virtual check-ins	Established-patients only.	New and established patients.
Practitioners eligible to provide virtual check-ins	Practitioners who can bill E&M codes.	Practitioners who do not bill E&M codes also may provide virtual check-ins, such as physical therapists, occupational therapists, speech language pathologists, licensed clinical social workers and clinical psychologists.
Beneficiary consent	Must be documented in patient's record.	May be obtained at the time the service is delivered.

Figure 3. Medicare Virtual Check-Ins: Pre/Post COVID

Virtual check-ins. These are typically brief phone calls that would not normally occur in person. Before the pandemic, these could be offered only to established patients and by "eligible providers"—clinicians who can bill for E&M codes (e.g., physicians, NPs, PAs, midwives, nurse anesthetists, etc.).

What changed? A far broader range of providers can offer virtual check-ins, and service may now be offered to new patients. For a before-and-after comparison, see Figure 4.

Commercial plans: Moving forward

Many commercial plans have expanded coverage for telehealth services. Some of this has been in reaction to state mandates, but much has been voluntary. Specifics vary by the insurer and state.

The most common change, Augenstein says, is coverage parity: If a service is covered in person, it's required to then be covered when delivered via telehealth. Payment parity—which means the service is paid at the same rate—is also common.

Don't expect to see these rolled back, he says. "We're starting to see that some plans are beginning to announce they'll keep these changes in place permanently." For example, BlueCross BlueShield of Tennessee announced it would be making its temporary COVID telehealth coverage policy permanent (*Becker's Hospital Review,* May 14, 2020).

"We think in general, the level of coverage in the commercial market will be broader than it was pre-COVID. Maybe not as broad as it is today, but more than there was coming into the pandemic," Augenstein says.

Medicaid: Ongoing change

Prior to the pandemic, many states had implemented broad Medicaid coverage for telehealth. Now we see more expansive coverage policies emerging.

There are a few levers that states have chosen to enable coverage

Issue	Traditional Rule	New Rule During the COVID-19 Pandemic
Beneficiary location (originating site)	Generally must be in a practitioner's office of facility located in a rural area. May be at home only for SUD or ESRD services.	Patient may be located anywhere.
Telehealth technology	Must be an interactive telecommunications system; cannot be a phone.	Must be a two-way, real-time interactive communication; phones permitted.
Services eligible for telehealth	Generally E&M and psychotherapy.	Expanded list includes observation care, critical care, group psychotherapy.
Eligible Practitioners	Only those who provide E&M services.	Physical/ occupational therapists, others included.
Audio-only services	Not considered telehealth and not reimbursable.	Considered telehealth and reimbursable.
Payment rate	Practitioner paid at lower, facility-based rate.	May be paid non-facility rate if located outside a facility.

Figure 4. Medicare Telehealth: Pre/Post COVID

during the pandemic including payment parity, out-of-state licensure, flexibility in modality (e.g., allowing telephone visits) and suspending prior authorization requirements.

A broader array of providers can bill for telehealth services, including dentists, optometrists and a wide range of behavioral health providers—but not pharmacists. Medicaid programs are also increasingly covering several other telehealth services, including well-child visits and tele-dentistry.

More temporary changes

"We have to remember that a lot of the changes that have been made are temporary," Augenstein explains. He points to three in particular.

- **HIPAA:** The HHS Office of Civil Rights has *temporarily* waived federal enforcement of HIPAA in regard to telehealth. In short, he explains, OCR is not going to impose penalties for *good-faith* violations of HIPAA privacy, security and breach notification rules by telehealth providers. In addition, for now, providers may use unencrypted platforms (e.g., FaceTime).

- **Licensure flexibility:** Providers, as a rule, may practice only in the states where they hold a license. However, because of COVID-19, all 50 states and the District of Columbia have introduced some level of licensure flexibility. "Some states may keep them in place, but I think the vast majority will remove those flexibilities post-COVID."

- **Controlled substance prescribing:** CMS and the DEA have *temporarily* waived provisions of the Ryan Haight Act to allow practitioners to prescribe Schedule II–V controlled substances via telemedicine without an initial in-person medical evaluation, provided that certain conditions are met. This specific change will be rolled back, but permanent changes may be on the horizon, he says. The DEA already had plans in place to issue guidance related to tele-prescribing of controlled substances—guidance that could create more flexibility for prescribers, he says.

What lies ahead

Few doubt that telehealth will continue to expand. CMS Administrator Seema Verma has frequently indicated that many of the advances made in telehealth are here to stay: "I think the genie's out of the bottle on this one. I think it's fair to say that the advent of telehealth has been just completely accelerated, that it's taken this crisis to push us to a new frontier, but there's absolutely no going back." (*The Wall Street Journal,* April 26, 2020.)

Badowski believes this pandemic-driven expansion will be the push that telehealth needed. "And I really think from the comprehensive medication management standpoint, this is something that can easily be done face-to-face, or via telehealth. I'm really excited to see a lot of the opportunities that do come out of this."

> **"In some cases they may see it as a business differentiator; in other cases they may truly appreciate the value of it. Their claims data may be showing reduced cost, improved adherence and/or overall improved outcomes."**
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> *Jared Augenstein, MA, MPH*
> *Director, Manatt, Phelps & Phillips, LLP*

She does have one major concern: Because CMM delivered via telehealth is so new, there's a dearth of implementation and evaluation data. Practices need to collect this data and evaluate their own progress. (See sidebar on next page for details on how to accomplish this.)

Augenstein is cautiously bullish. "I think it's going to be a bit of a mixed bag." But although many provisions will be rolled back, he anticipates increased state legislative activity around coverage and payment parity bills, which would require plans to cover telehealth.

And even in states that don't take action, health insurers may decide to

Tele-CMM: Evaluation and assessment

Any newly launched innovation requires careful, ongoing assessment, and that applies to tele-CMM, Badowski explains. She shares a couple of tools to help with implementation and evaluation.

"There are a few indicators that we're able to actually measure, and this should be something that is done on an ongoing basis."

- **Acceptability:** The perception among stakeholders that a given innovation is agreeable and satisfactory.
- **Adoption:** The intention, initial decision or action to try to use an innovation.
- **Appropriateness:** How will this fit your institution and targeted patient population?
- **Cost:** "If it's not feasible based on cost, we're not going to have that buy-in." Her advice: Engage a health economist at the outset, and review ROI throughout.
- **Feasibility:** Will it work in your particular setting?
- **Fidelity:** The degree an innovation is implemented without deviation. (Fidelity is essential to CMM.)
- **Penetration:** How well an innovation will integrate within your system.
- **Sustainability:** Will this be institutionalized, or will it be viewed as a one-off?

"This is something that is obviously going to evolve, so performance measures should be identified and measured over time, not just at the beginning of the implementation phase," she explains. Figure 5 identifies each of these indicators and shares examples of how they can be effectively evaluated.

Global QA assessment tool for CMM

As you implement a CMM telehealth program—or, for that matter, CMM—you need to ensure quality. Badowski shared a resource to help practices do just that: the CMM Practice Management Assessment Tool (PMAT). It provides a global assessment of domains of comprehensive medication management practice.[3]

It assesses the domains and essential components of CMM practice management and prioritizes and guides areas for improvement. Each domain consists of two to three essential components of CMM practice management for a total of 13 components. Each component contains several questions which collectively form a 78-item descriptive practice management assessment tool.

[3] Pestka DL, Frail CK, Sorge LA, et al. "Development of the comprehensive medication management practice management assessment tool: A resource to assess and prioritize areas for practice improvement." *J Am Coll ClinPharm.* 2019;1–7. https://doi.org/10.1002/jac5.1182

Indicator	Definition	Example Methods of Evaluations
Acceptability	Perception among stakeholders that a given innovation is agreeable, palatable or satisfactory	Evaluate before intervention and 3-6 months post implementation (every 6 months thereafter)
Adoption	Intention, initial decision or action to try or use an innovation	
Appropriateness	Perceived fit	
Feasibility	Extent to which a innovation can successfully be used or carried out in a given setting	

Badowski ME. Pharmacotherapy 2018;38(2):e7–e16.

Figure 5

The five domains: organizational support, care delivery processes, care team engagement, evaluation of services and ensuring consistent and quality care. "Obviously, we want to make sure that we are providing that same care through telehealth that we would be providing face-to-face."

The first part provides a global assessment of practice management domains. The second part includes detailed questions relating to all essential components. The third guides users in the next steps of practice management and improvement.

She shared some of the questions.

- Is there consistent training and retraining to ensure everyone on the team understands the philosophy of CMM practice and the patient care process?
- Does the employer provide financial support—and time off—for continuing professional development?
- Are processes in place to ensure documentation is clinically sound and accurately completed? If so, is the information used to improve the CMM practice?
- Performance: On a scale of 0-10, how would you rate ensuring consistent and quality care of your CMM practice?
- Feasibility: On a scale of 0-10, how would you rate the feasibility of improving ensuring consistent and quality care in your CMM practice?

"Since telehealth is a newer area for CMM, we definitely need to make sure that this does occur," Badowski says. It's particularly crucial because of the current lack of data on quality for CMM in telehealth encounters. "We want to make sure that we're getting this out to people, we're publishing this, we're showing our outcomes and results. I think that's definitely a very important part of this thought process." ■

do so voluntarily. "In some cases they may see it as a business differentiator; in other cases they may truly appreciate the value of it. Their claims data may be showing reduced cost, improved adherence and/or overall improved outcomes."

He expects several Medicare provisions to remain in place, including the expanded list of eligible providers and the increased rural flexibility. He also expects expanded Medicaid coverage and payment; although, this is going to vary considerably by state. "All things considered, there will be more coverage for telehealth services in 2021 than there was in 2019."

As that happens, he says, the conversation must move from "Is telehealth good?" into something more meaningful, something that draws on the experiences of the past few months. "Telehealth can be transformative. Now, the question is 'how do we ensure that everyone has an opportunity to use it, especially our most vulnerable patients?'" GTMR

About the Experts

Melissa Badowski, Pharm.D., MPH, FCCP, BCIDP, BCPS, AAHIVP
Clinical Associate Professor, Section of Infectious Diseases Pharmacotherapy, Department of Pharmacy Practice, University of Illinois at Chicago, College of Pharmacy

MELISSA BADOWSKI received her Pharm.D. degree from Midwestern University, Chicago College of Pharmacy in Downers Grove, Illinois and her MPH

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About the Experts *(continued)*

degree from the University of Illinois at Chicago, School of Public Health. She completed her PGY1 pharmacy practice and PGY2 pharmacotherapy residencies at the University of Maryland Medical Center and College of Pharmacy in Baltimore. Her specialties and research interests include HIV and infectious diseases.

On completion of her residencies, Badowski became an assistant professor at the University of Maryland College of Pharmacy. In 2010, she joined the University of Illinois at Chicago, College of Pharmacy. She currently treats patients with HIV in the Illinois Department of Corrections through telemedicine. In 2014, Badowski became the founding chair of the American College of Clinical Pharmacy's HIV PRN. She also serves on the Board of Pharmacy Specialties as a member of the Pharmacotherapy Specialty Council and a committee review member for the National Association of Boards of Pharmacy.

Jared Augenstein, MA, MPH
Director, Manatt, Phelps & Phillips, LLP

JARED AUGENSTEIN is a director with Manatt Health, an interdisciplinary policy and business advisory practice of Manatt. He provides strategic advisory services, project management, policy analysis and startup business planning to health care providers, health tech and services companies, states, payers, biotech companies and health care associations and foundations. Jared's primary areas of focus are advising public—and private—sector clients on strategic planning, digital health, telehealth, delivery system transformation, population health and federal and state health policy trends. Jared earned a BA from Vassar College and an MPH and MA from Yale University.

8230 Old Courthouse Road, Ste. 420
Tysons Corner, VA 22182
703.394.5398 ▪ www.gtmr.org

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