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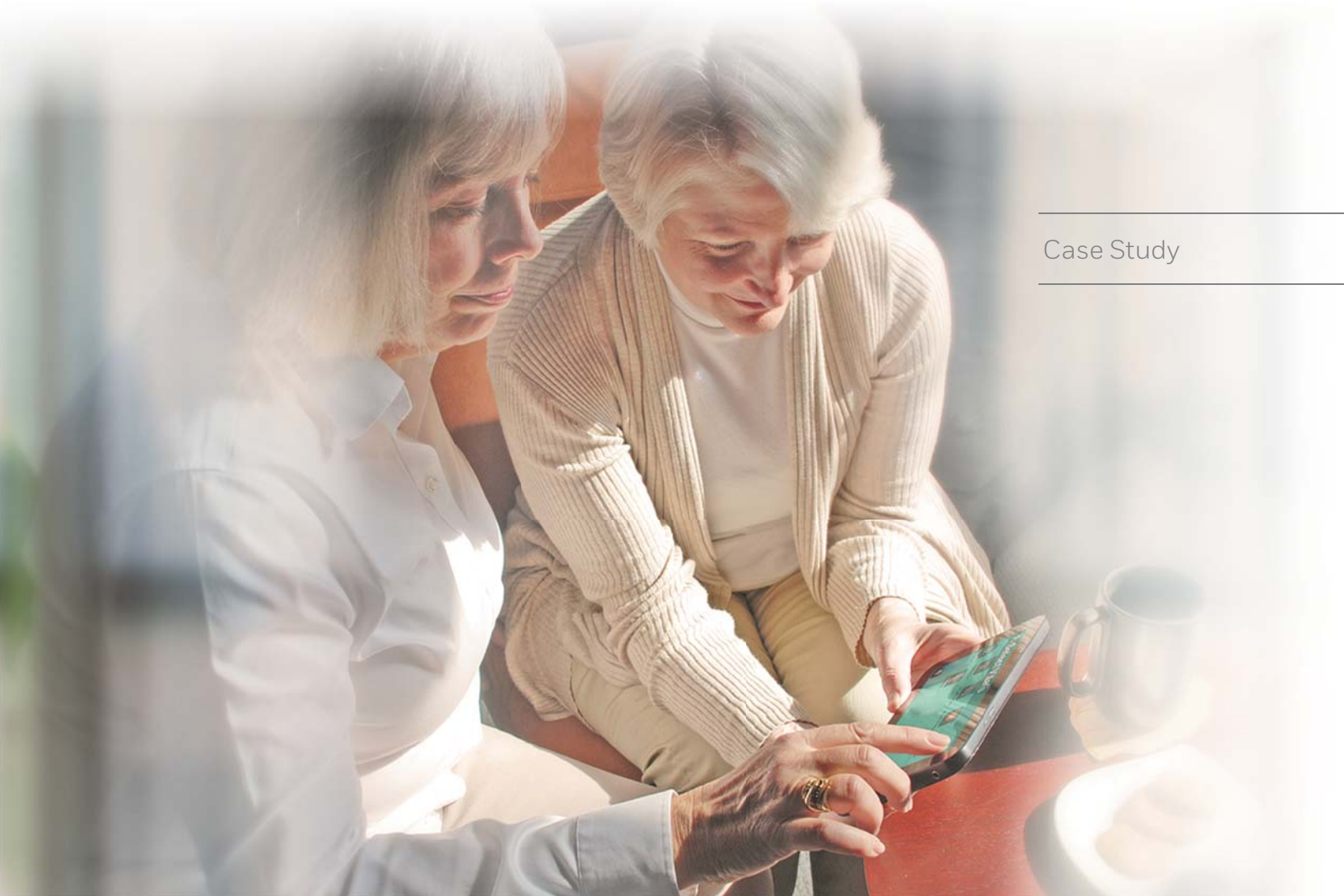
Using Telehealth to Increase Revenue Opportunities in the Fee-for-Value Transition

According to recent reporting from the ONC, healthcare spending in the United States reached $2.6 trillion in 2010, a total of 17.6 percent of the national gross domestic product (GDP). Tracing the arc of that same growth trajectory, by the year 2020 healthcare will make up nearly 20 percent of the GDP.



Case Study

As healthcare costs continue to skyrocket, there hasn't been a reciprocal increase in overall good health – in fact, many Americans are not receiving the care recommended to them, and nearly half of all Americans suffer from chronic disease such as diabetes or hypertension.

A Healthcare Revolution: Telehealth and the Transition to FFV-based Payments

Since its inception, telehealth has been touted among healthcare industry leaders as a revolutionary concept with the potential to address healthcare's greatest challenges. And truly, the past decade has seen remarkable results: Healthcare organizations have reported successful patient outcomes through the utilization of telehealth services, including reductions in readmissions rates, increased patient satisfaction and quality of care, and improved clinical efficiencies.

With FFV requirements now in place, policy makers on Capitol Hill have also recognized the potential of telehealth to streamline care across the continuum, and are working to make it more accessible for healthcare providers as part of the FFV transition process. The Telehealth Promotion Act (H.R. 6719) is poised to increase federal support and payments for telehealth services nationwide, while also proposing a series of improvements to existing Medicare and Medicaid programs to augment the role and impact of telemedicine.

But in order to examine the pivotal inflection points where telehealth can make substantial positive financial gains for hospitals and ACOs as they move from the FFS reimbursement system to one based on value, it is necessary to look at the areas of greatest challenge involved, and three of those are as follows:

- Achieving Shared Savings Bonuses;
- Tracking Quality Measures; and
- Optimizing New Revenue Streams

Achieving Shared Savings Bonuses through Cost-effective Care

Value-based payment contracts are in their infancy, and most are structured according to a shared savings model which – in general – incentivizes providers to reduce spending for a defined patient population by offering them a percentage of any net savings they realize.

For example, today Medicare continues to reimburse health systems on a FFS basis, and at the end of the year, shared savings bonuses are calculated. Each provider is benchmarked against the rate of increase for the overall FFS population. If a hospital improved – i.e. they spent less money – than in the average FFS population, they qualify for a bonus – a piece of the overall savings.

In order to qualify for a piece of this "shared savings pie," a hospital or ACO has to know every patient, what services they're getting, what it costs, and how it compared to the contract – with the triple-aim challenge being how to reduce overall care costs, while increasing quality of care and keeping patients healthier in the longer-term to avoid readmission penalties.

Telehealth solutions are the perfect companion to hospitals and ACOs in this new world order because they have the same overarching goal: making healthcare delivery more efficient (costeffective) while simultaneously increasing quality of patient care. This is accomplished through the reduction of avoidable readmissions by improving patient care transitions: Because biometrics are regularly monitored with a remote device after a patient's hospital discharge, any change in health can be assessed by trained medical staff and addressed immediately.

Tracking a Wide Variety of Quality Measures

The value-based incentives and penalties also rely on quality measures to demonstrate healthcare providers are meeting quality standards and benefitting patients, in conjunction with cutting costs from the system. This is intended to give physicians financial incentives to work together and proactively intervene to keep patients healthy, rather than wait to treat them after their health has deteriorated—something that the traditional FFS payment method has encouraged.

The 33 different quality measures Medicare is currently tracking examine how well doctors coordinate with each other, whether patients receive appropriate preventive services, whether they suffer unnecessary harm and how patients experience their treatments.

While many hospitals and ACOs are grappling with the tools to track the new quality measures, there are technology solutions already on the market to help them. Many telehealth solutions feature back-end software support which allows healthcare providers to tie hard data points to the quality of care for each patient. Honeywell's LifeStream Management Suite, for example, offers analytical tools to help healthcare providers track patient outcomes and patient case load for each care provider, as well as hospital admissions – and readmissions – based on patient diagnosis.

Optimizing New Revenue Streams as FFS Revenue Drops

For hospitals and ACOs, the transition from FFS to value-based reimbursement has the potential to be a bumpy one at best, especially from a financial standpoint. Overall revenue has the likelihood of decreasing, because the pressure on a hospital's FFS revenue will increase faster than it can grow its value-based reimbursement dollars.

The key to succeeding through the transition time period—and beyond—is to continue to implement solutions that have the potential to cut costs, while also identifying new sources of revenue. Here too, care providers can use telehealth to carve out new programs and services to increase new revenue coming in, while simultaneously cutting costs throughout the system – as in the case of Franciscan Alliance.

Case in Point: Franciscan Alliance

The Franciscan Alliance Accountable Care Organization (ACO) in Indiana was among the first in the country to partner with Medicare. With an aim to bring down the overall costs of medical care, it provides coordinated, comprehensive care across hospitals, physician practices, a home health agency and other healthcare providers.

Its home health agency, the Franciscan Visiting Nurse Service (VNS), has successfully provided a reduction in overall hospital readmission rates through traditional telehealth services (it boasts readmission rates that typically hover well below 10 percent – well below the national average that is still closer to 20 percent). By using its expertise with remote patient monitoring (RPM), it was also able to identify and implement a new program that created a new revenue stream for the Alliance: the Patient Health Coaching Program.

The Coaching Program is a joint effort between the Franciscan VNS and one of the ACO's physician groups, and looks to impact the prognosis long-term. This is accomplished through the Program's four areas of emphasis:

- Creating a **Personal Health Record** (PHR) to improve communication across the care continuum;
- Identifying **Red Flags** to provide early intervention points for the patient and telehealth nurses to be aware of;
- Implementation of a Medication **Reconciliation and Self-Management** process to ensure patient understanding around prescribed medications; and
- Preparing patients to be actively involved in their care during any Follow-up Visits that may occur.

The physicians, telehealth and home health nurses involved in the Program use Honeywell's Genesis DM and Genesis Touch RPM devices to keep regular tabs on the ongoing health status of their enrolled patients, and track the progress of long-term patient health using Honeywell's analytical software.

In order to understand the level of program success, 70 percent of the patients enrolled in the Patient Health Coaching Program are monitored via RPM daily, and their health results are compared against not only the general population of patients in the Franciscan Alliance system, but against those patients also using traditional telehealth monitoring following hospital discharge. Data is tracked month by month for comparative purposes, as well as year by year.

The Results Are In

Data results from Franciscan VNS indicate the Program's high rates of success from cost-savings and quality of care standpoints – a readmission rate that hovers around five percent on average, medication reconciliation rates in the high 40 percent range, and a 95 percent patient retention rate in the Program, due to a high rate of patient satisfaction. Patients have also reported life changes based on the results they see every day through their RPM devices, and enrolled diabetes and CHF patients have increased their levels of exercise and decreased their daily caloric intake to keep weight down and heart-healthy activities up, underscoring the long-term objective of the program.

In comparison to the typical FFS Medicare population – with twenty percent readmission rates as the norm – Franciscan Alliance qualifies for a larger than average slice of CMS' shared savings pie. In fact, by the three standards proposed herein – **achieving shared savings bonuses, tracking quality measures and optimizing new revenue streams** – Franciscan Alliance is well poised to be ahead of the pack.

In Conclusion

Examining three pivotal inflection points where telehealth can make substantial positive financial for hospitals and ACOs as they move from the FFS reimbursement system to one based on value, it is clear that aiming to achieve 1) shared savings bonuses, 2) track quality measures and 3) optimize new revenue streams can be instrumental to succeeding through the transition time period—and well into the future.

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