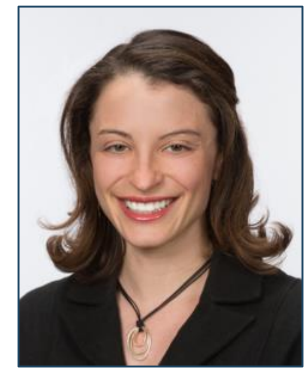
Policy Action Task Group

Ruth Carlos, MD, MS



Sarah Downer, JD

Andrea Borondy Kitts MS, MPH

NLCRT – POLICY ACTION TASK WORK GROUP – COST OF CARE

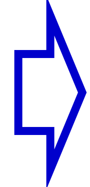
Tina Tailor, MD and Ruth Carlos, MD
Duke University and University of Michigan

Testing is not a benign procedure

Downstream cost after LDCT

OPTUM CLINFORMATICS

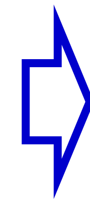
- Claims data
- Employer-insured



POPULATION

- 55-79 yo with LDCT LCS 2015-17
- 12mo continuous enrollment after LDCT

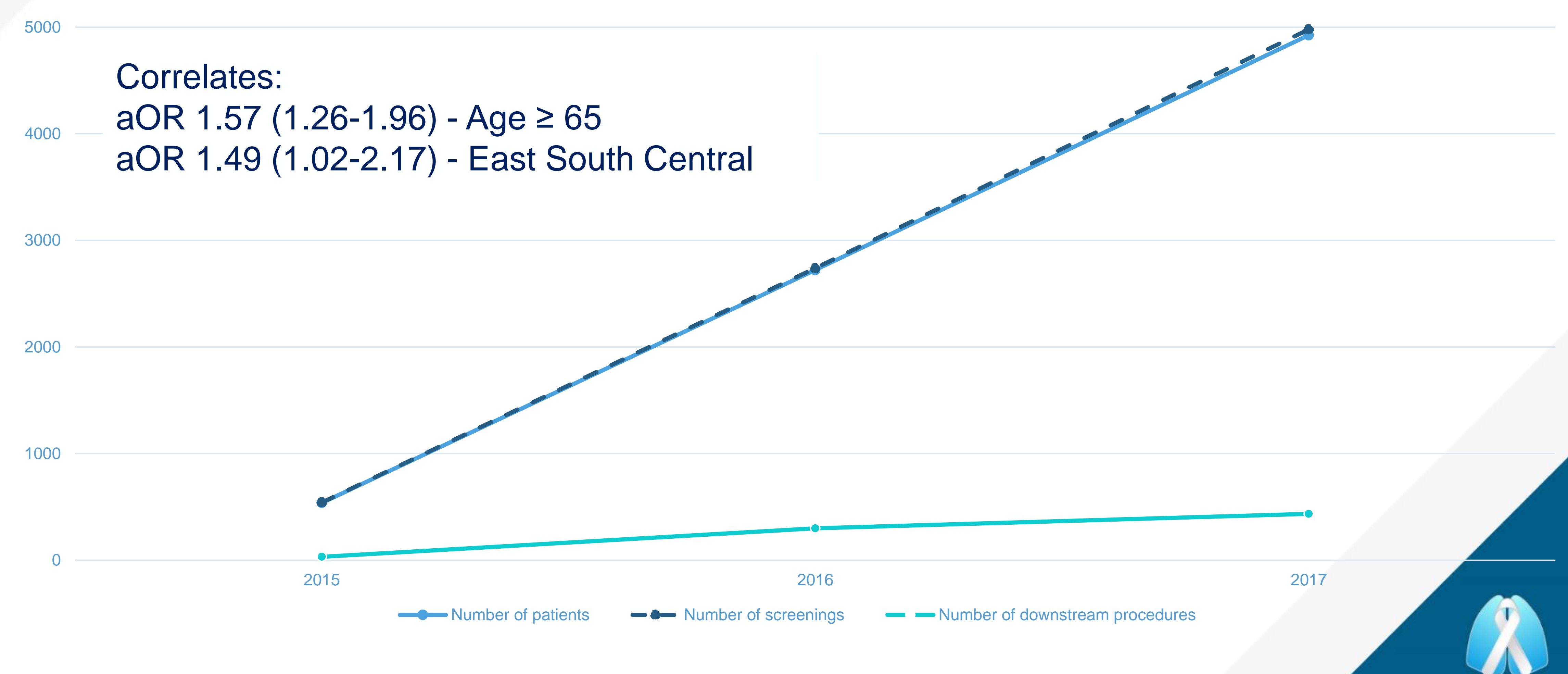
Asian	104 (1.4%)
Black	533 (7%)
Hispanic	269 (3.6%)
White	6,224 (82.2%)
Unknown	439 (5.8%)



OUTCOMES

- Invasive procedures
- Patient OOP

Frequency of invasive procedures



NLCRT
NATIONAL LUNG CANCER ROUNDTABLE

Costs of care

	LCS resulting in downstream procedures	LCS NOT resulting in downstream procedures	Downstream procedure resulting in screen-detected cancer	Downstream procedure NOT resulting in screen-detected cancer
Total number of LDCT	507	7751	112	395
Total cost per LDCT episode, median (IQR)	1298.0 (555.6-4853.4)	92.7 (90.5-361.3)	17200.7 (3659.3-38256.9)	872.0 (439.4-2417.0)
OOP cost per LDCT episode, median (IQR)	49.3 (0-434.2)	0 (0-0)	438.3 (0-1419.6)	30.7 (0-235.2)

Policy implications

- Alternative models of reducing downstream cost of care burden
- HEDIS measure development
- Health equity focus

Thank You

NLCRT – POLICY ACTION TASK WORK GROUP – TELEHEALTH

Andrea Borondy Kitts MS, MPH
Rescue Lung Rescue Life Society

Disclosures:

Board member Rescue Lung, Rescue Life Society

COO & Investor *Prosumer Heath*; a start-up company developing an AI driven individualized mobile health platform to help individuals manage their health and healthcare

Associate Editor Journal of American College of Radiology

Paid faculty Medtronic Global Lung Health Summit

Consulting fees Astra Zeneca

Telehealth Use Across the Continuum of Lung Cancer Risk Reduction and Care

- Shared decision making
- Tobacco counseling
- Symptom monitoring & palliation
- Clinical trial participation

Screening → Diagnosis → Treatment → Survivorship

CMS Relaxed Telehealth Rules during the COVID19 Public Health Emergency

- EXPANSION OF TELEHEALTH WITH 1135 WAIVER: Medicare payment for office, hospital, and other visits furnished via telehealth
  - Delivered by doctors, nurse practitioners, clinical psychologists, and licensed clinical social workers
  - Medicare telehealth visits, virtual check-ins and e-visits
  - Not auditing for prior relationship
  - In healthcare or home setting
- Medicare pays the same amount for telehealth services as it would if the service were furnished in person.
- For CT lung screening licensed independent providers can provide the shared decision-making counseling via a telecommunication device
  - Visit can be conducted over the phone

Medical Societies and Organizations – including HHS and CMS - are Advocating for Making Temporary Telehealth Rules Permanent

“It’s taken this crisis to push us to a new frontier, but there’s absolutely no going back,” said Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma to The Wall Street Journal. [1] “I think we need to do everything we can to support the health care system, make health care more accessible, make it more affordable—and telehealth is one powerful tool that can solve a lot of the problems that we have.”[2]

Telehealth-1

AMA passes pro-telehealth resolution

by KatJercich | Nov 25, 2020 | Telehealth | 0 comments

“We’re now aggressively looking at how to make the telehealth revolution a permanent part of American medicine,” wrote Health and Human Services (HHS) Secretary Alex Azar. “In many cases, well-meaning anti-fraud and privacy measures make it more difficult than it needs to be. There’s a reluctance to let Medicare pay for more telehealth on the grounds that this will drive up health care utilization, straining our health care system and the program’s budget. That kind of static thinking is one of the biggest problems in American health care. We shouldn’t stand in the way of delivering necessary health care services in the most convenient way possible—especially as our health care system shifts toward paying for outcomes rather than procedures.”[3]

1 *The Doctor Will Zoom You Now*, *Wall Street Journal, April 26, 2020.*
2 *The New Normal of Care Delivery*, *Health IT Leadership Roundtable, July 2020.*
3 *Trump Administration Aims to Keep Telehealth Revolution Here to Stay, Azar, USA Today, July 31, 2020*

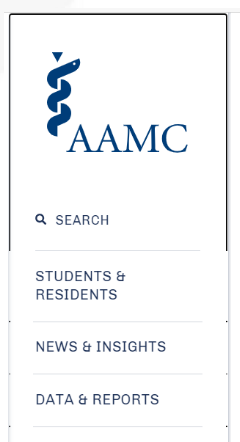
Taskforce on Telehealth Policy (TTP) Findings and Recommendations

Latest Evidence: September 2020

Top-Line Findings

- Telehealth is healthcare's natural evolution into the digital age, not another type of care
- Telehealth can be critical tool in advancing a well-coordinated, patient-centered, value-optimized health care system
- COVID-19 flexibilities generated new evidence and adaptations that question restrictions from when technology was less mature and use cases more limited

Academic Medical Societies are Identifying Skill Domains and Developing Competencies to Educate and Train Clinicians in Telehealth Specific Skills



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AAMC Telehealth Initiatives and Research

Pre-publication: New Cross-Continuum Competencies in Telehealth

The AAMC and its Telehealth Advisory Committee have developed telehealth competencies across the continuum of UME, GME, and CME with input from a broad range of stakeholders. The competencies are intended to guide educators developing curricula as well as students learning to practice and professionals continuing their development. Upon formal publication, they will be included in the New & Emerging Areas in Medicine Series. If you have questions, please contact us.

Project CORE: Coor

VIRTUALCARE

Crossing the Virtual Chasm: Rethinking Curriculum, Competency, and Culture in the Virtual Care Era

DATE: Thursday, September 10, 2020

TIME: 9:00-2:00pm PST/12:00-5:00pm EST

https://www.aamc.org/system/files/2020-09/hca-telehealthcollection-telehealth-competencies.pdf

Increased Use of Telehealth Will Lead to Additional Disparity Unless We Design Upfront to Address the Digital Divide

At least 1 in every 4 Americans may not have digital literacy skills or access to Internet-enabled digital devices to engage in video visits.

Vulnerable populations at risk of being left behind

- Older Americans
- Rural residents
- Low Income populations
- Racial and ethnic minorities
- Individuals with limited digital literacy or access
- Individuals with limited health literacy
- Individuals with limited English literacy
- Individuals with Hearing or Sight limitations

Sarah Nouri, MD, MPH, et al., Addressing Equity in Telemedicine for Chronic Disease Management During the Covid-19 Pandemic, https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0123

Telehealth Strategies

Support efforts to make telehealth emergency rules permanent

Advocate for universal broadband access

Support Federal Communications Commission (FCC)'s Lifeline program that provides phone and broadband internet service to low-income individuals Lifeline Program for Low-Income Consumers | Federal Communications Commission (fcc.gov)

Support increased funding and planning for telehealth infrastructure including broadband and internet-connected devices for both physician practices and patients

Thank You

NLCRT – POLICY ACTION TASK WORK GROUP – STRATEGIC PLAN

Sarah Downer, JD
Center for Health Law & Policy Innovation

Call to Action: Lung Cancer Policy

- In progress: ***Policy Strategies for Improving Control and Care in Lung Cancer: A Call to Action***

- Charge of the Policy Task Group → identifying policy pathways that will ensure high quality, affordable care across the continuum, from risk reduction to survivorship.

Key Services Across the Lung Cancer Control Continuum: Examples

Cancer Control Continuum	Key Services	Barriers to Key Services
Risk Reduction	Tobacco cessation	Lack of health insurance coverage for tobacco cessation counseling and medications
Screening	LDCT screening for individuals at heightened risk of developing lung cancer	Gaps in coverage for high-risk individuals
Diagnosis	Timely scans that follow up on abnormal screening results	Cost-sharing on follow-up scans; failure to follow
Treatment	Access to medications and curative procedures	Provider bias in recommending course of treatment; gaps in genetic biomarker testing
Survivorship	Services that increase quality of life (pulmonary rehabilitation, nutrition interventions, etc.)	Lack of coverage
Cross-Continuum	Accessible and culturally competent care, including multilingual services	Restrictions on telehealth; lack of transportation, failure to use medical translators

Vision

1	A robust body of research demonstrates the efficacy and value of key services to ensure their integration into care delivery and financing.
2	Key services are sustainably funded through insurance reimbursement or other recurrent funding.
3	Knowledgeable health care providers have incentives to refer for the most effective preventive services, screening, diagnostic testing, treatment, and supportive care.
4	Health care payers are incentivized to connect patients to, and cover, key services.
5	Key services are accessible (both financially and practically) to the individuals who need them.
6	Proposed policies explicitly recognize and respond to historical and current discrimination based on race, gender and gender identity, sexual orientation, disability and more, that contributes to disparities in lung cancer prevalence and prognosis.

Identification of Policy Pathways

Example: Sustainable Funding of Key Services

Landscape overview:

- Lack of equitable access to comprehensive health coverage
- Expanded access to short-term, limited duration health plans that do not have to meet ACA mandates for coverage under the Trump Administration → increase in people who are underinsured
- Lack of Medicaid expansion in 14 states leaves adults under 100% of the Federal Poverty Level without access to affordable insurance
- Increase in high-deductible health plans causes people to delay screenings and even treatment

Policy Pathways:

- Rescind the Executive Order that expanded access to short-term, limited duration insurance.
- Require short-term, limited duration insurance to abide by ACA consumer protection rules (federal- **or** state-level action).
- Expand Medicaid in all states for all residents up to 138% FPL.

IDENTIFICATION OF POLICY PATHWAYS

Example: Health Care Payers are Incentivized to Cover Key Services

Landscape overview:

- Even with ACA-compliant health insurance, gaps in coverage of key services along the continuum remain.
- Lung cancer screening is not covered in all state Medicaid programs.
- Genomic testing is not consistently covered.
- Interventions that increase treatment completion and efficacy and improve quality of life are not covered.
- Imposition of cost-sharing for screening and follow up scans erodes patient trust in the health care system and willingness to be screened.

Policy Pathways:

- All state Medicaid programs should cover LDCT screening for individuals who meet USPSTF screening eligibility criteria.
- States can require coverage of key services as a condition of granting license to operate in the state.
- HHS can issue guidance that addresses cost-sharing for scans that follow abnormal results of LDCT scans.
- CMS can include lung cancer screening as a Star Rating measure.

Thank You

Q&A Session

Closing Remarks

Ella Kazerooni, MD, MS
NLCRT Chair

Douglas Wood, MD
NLCRT Vice-Chair

Thank You!

December 7-8, 2020