Lasting Effects of COVID-19: Reimbursement Reform?

Reimbursement for our services as medical oncologists has always been a difficult issue for me. Payment based on evaluation and management codes historically has required a physical visit and laborious documentation, and the payments themselves barely kept the lights on. I was always miffed that even minor surgical procedures could bring in big bucks, but an hour spent talking a patient out of an unnecessary and costly procedure might be reimbursed at a rate less than an electrician fixing faulty wiring. It never made sense to me that cognitive care was so poorly valued. Of course, this is why adult and pediatric primary care specialities and psychiatry are struggling. Those who incur a big debt going to medical school will be less likely to consider these lower-paying jobs, especially in a community-based setting, though large HMOs and facility-based practices can ease the pain a bit through various funds flow models.

Thought leaders have generally agreed that reimbursement reform is needed but have had found little consensus on how to achieve that reform. Allowing "time" to be a factor in the visit has helped, but it hasn't leveled the playing field. The Centers for Medicare & Medicaid Services (CMS) led the way, and some but not all insurers have followed suit. Then a pandemic happened.

In a heartbeat (or so it seemed), CMS introduced flexibilities for provider and patient safety through the CARES Act.[1] Virtually every type of visit that does not absolutely require physical presence is allowable and reimbursable as a video visit or even a telephone call. Even email correspondence, through protected portals, is reimbursable. And the time spent reviewing records is now reimbursable. We can even "cross" state lines to treat patients who live in states in which we are not licensed.

To be fair, we don't yet know how this will play out in the long run financially, but so far I am cautiously optimistic. Ultimately, my point is that this miserable pandemic has made us examine how we provide care, and assess what is necessary and what is not. And CMS is providing payment for real work that previously was unbillable.

Virtually every opinion leader has agreed that telehealth and other remote activities such as monitoring are here to stay, though perhaps not with the current frequency. Patients like the convenience and the visits seem to take less time, allowing physicians to have higher capacity. As long as physicians are reimbursed properly, who would argue against it? Although the CARES Act theoretically will be repealed when the pandemic ends, I suspect elements that improve healthcare delivery, like telehealth payments, will remain.

Whoever thought a tiny strand of RNA could improve our healthcare system?

Reference

1. CARES Act, HR 748, 116th Congress (2019–2020). Pub L No. 116–136. Accessed October 8, 2020. Available at: https://www.congress.gov/bill/116th-congress/senate-bill/3548/text?q=product+actualizaci%C3%B3n

WHAT DO YOU THINK? To submit a Letter to the Editor, email JNCCN@nccn.org or log into www.editorialmanager.com/JNCCN.

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