Telehealth as a Workforce Solution

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IPHCA Annual Conference

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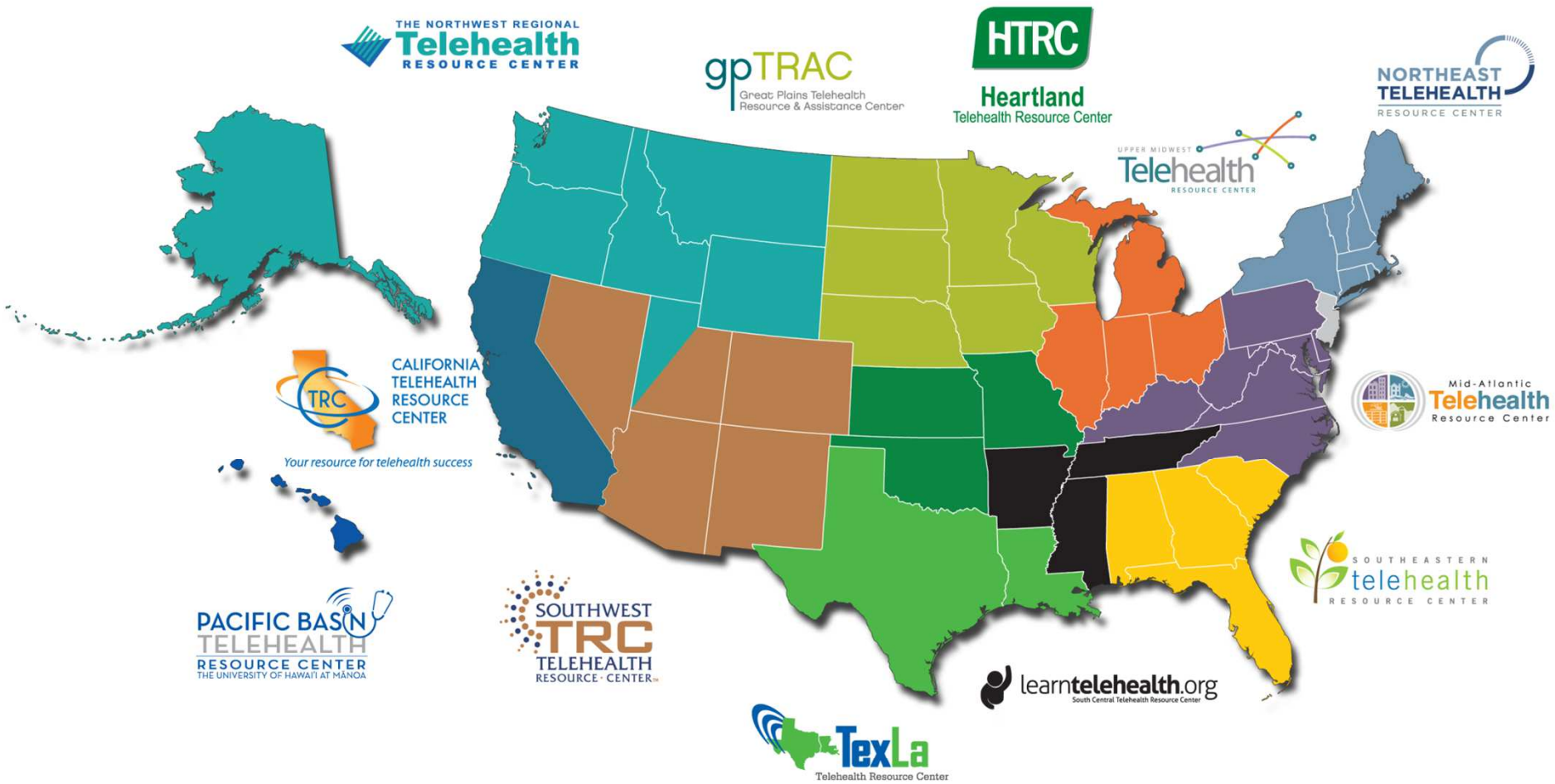
Outline

- UMTRC and National TRC Program
- Workforce Issues
- The Peer-to-Peer Model of Telehealth
- Examples of Workforce Successes
- Key Factors That Drive Success
- Questions

TelehealthResourceCenters.org



TTAC TelehealthTechnology.org National Telehealth Technology Assessment Resource Center

Center for Connected Health Policy

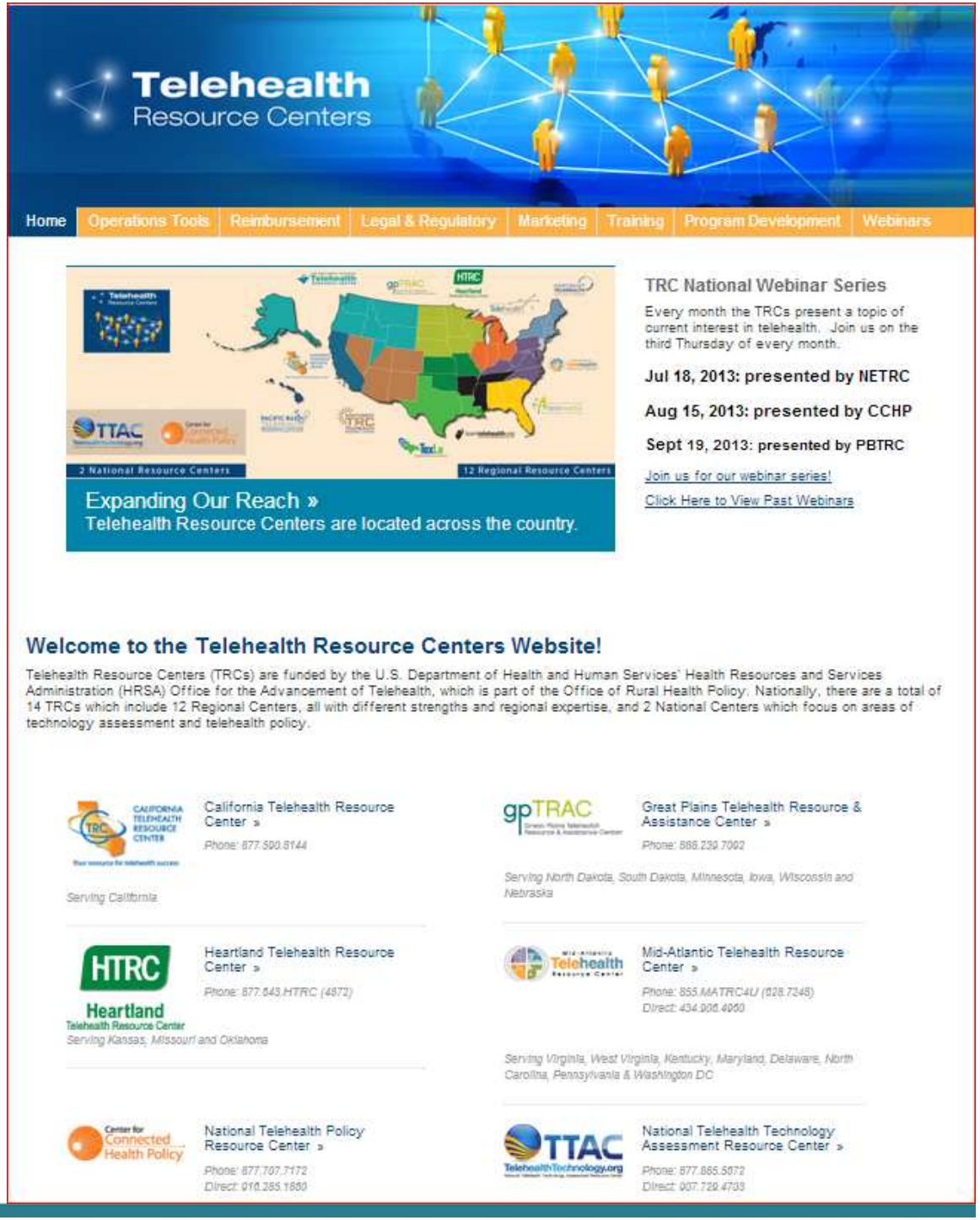
2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

12 Regional Resource Centers

telehealthresourcecenters.org

- Links to all TRCs
- National Webinar Series
- Reimbursement, Marketing, and Training Tools



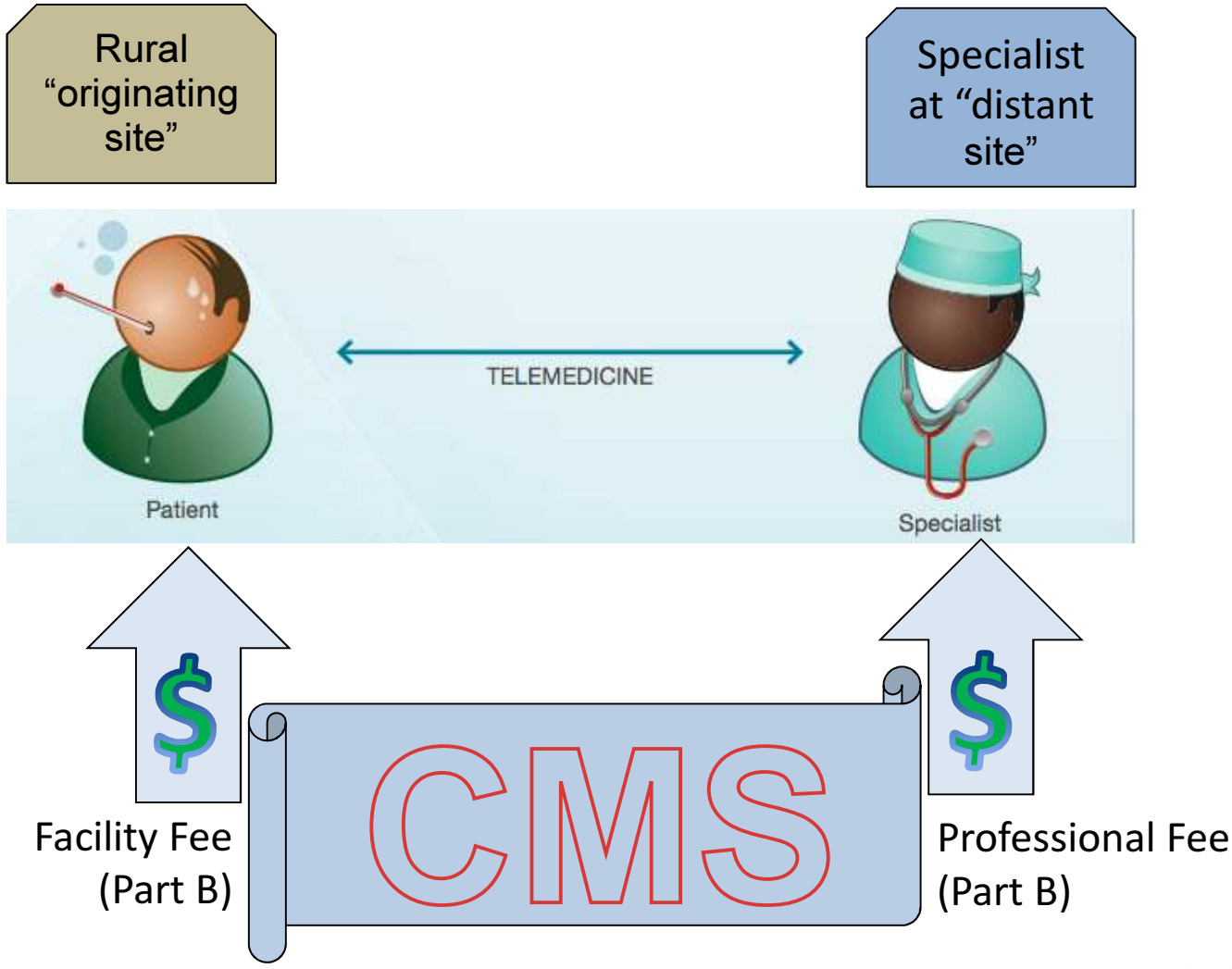
UMTRC Services

- Presentations & Trainings
- Individual and Group Consultation
- Training and Technical Assistance
- Connections with other programs
- Program Design and Evaluation
- Information on current legislative and policy developments

Workforce Shortages

- 20% of population is rural, but only 11.4% of physicians work in rural areas
  - Add “underserved” areas, and it gets worse
- 26% of physicians are age 56 or older
- 15% of population is 65 or older, and this number is growing fast
- Shortages exist (and will continue) in all segments of the healthcare work force

The Promise of Telehealth

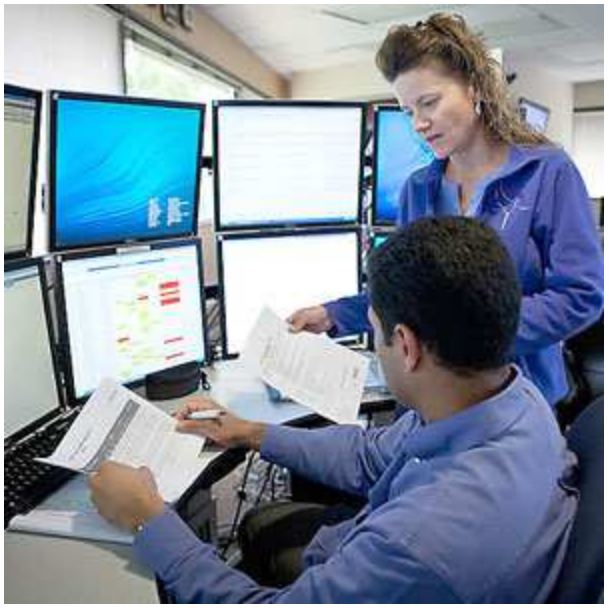


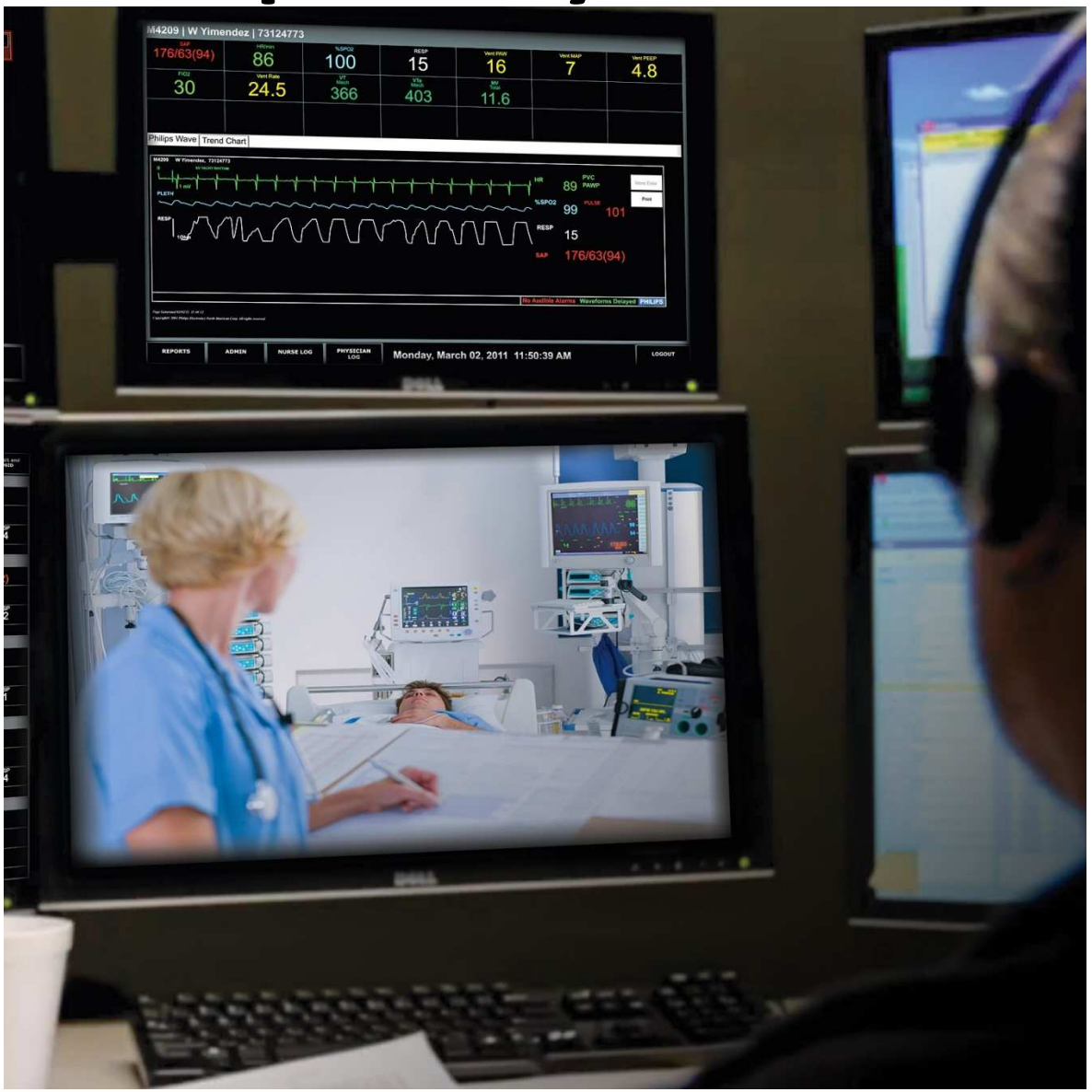
Three Domains of Telehealth

- **Hospital & Specialties**
  - Specialists see and manage patients remotely
- **Integrated Care**
  - Mental health and other specialists work in primary care settings (e.g., PCMH's, ACO's)
- **Transitions & Monitoring**
  - Patients access care (or care accesses patients) where and when needed to avoid complications and higher levels of care

****<u>Value proposition differs</u> among these types****

Hospital and Specialty Care





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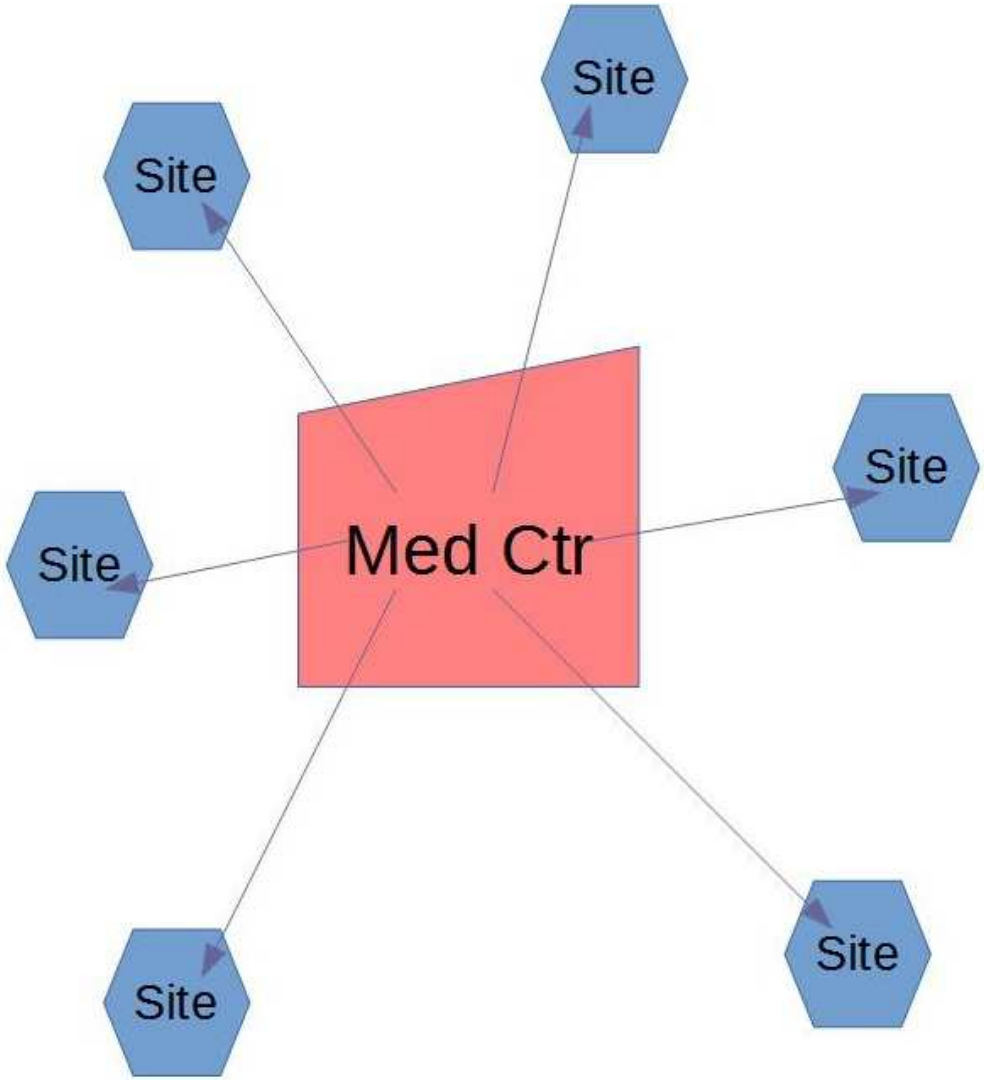
Integrated Primary Care

Hub & Spoke vs. Peer-to-Peer

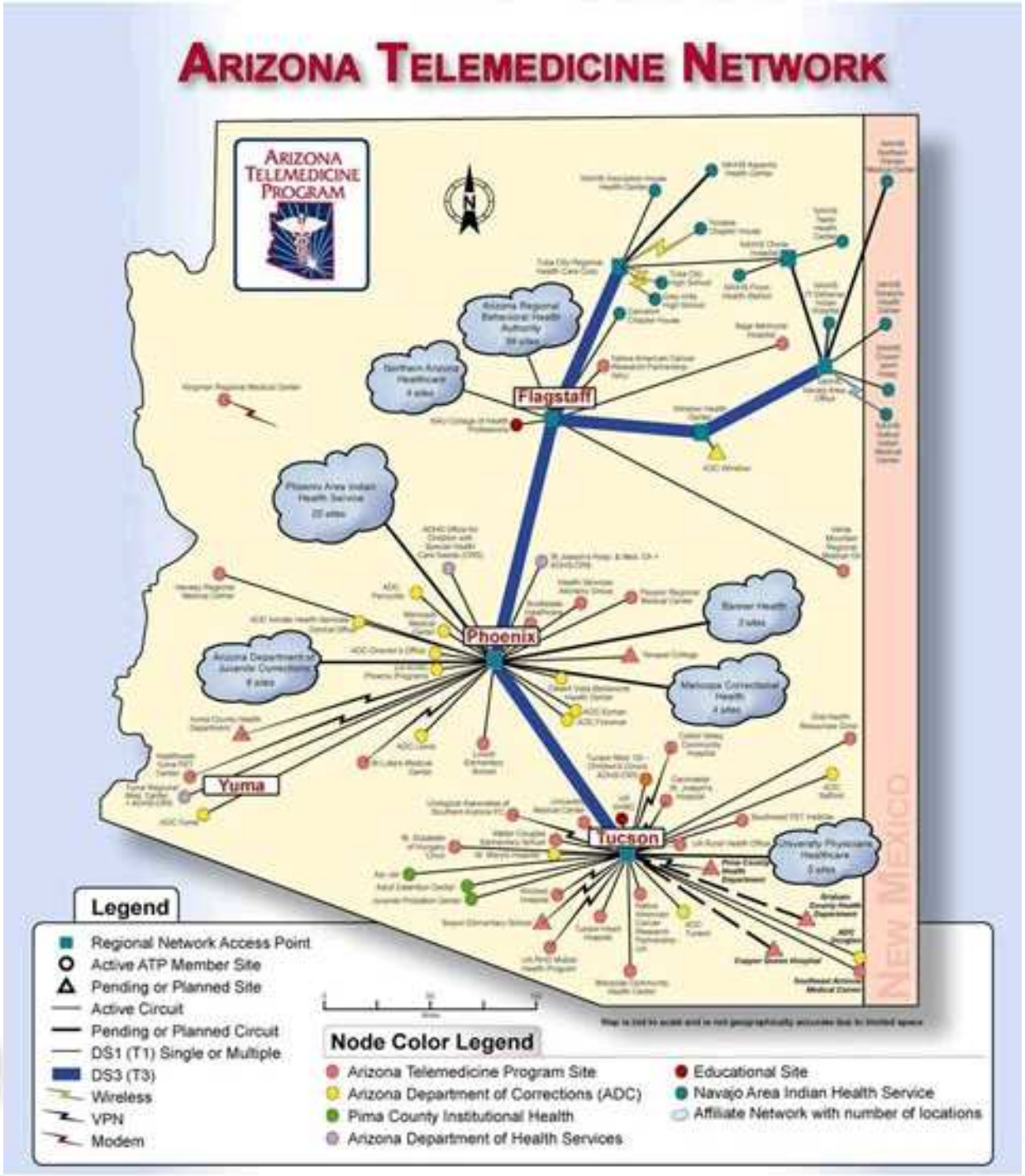
Background

- Early years of telemedicine focused on connecting urban resources to rural areas
- Most programs that explored/developed telemedicine services were urban/academic
- Most research was/is done from the perspective of the academic “hub” site

Hub & Spoke Telemedicine



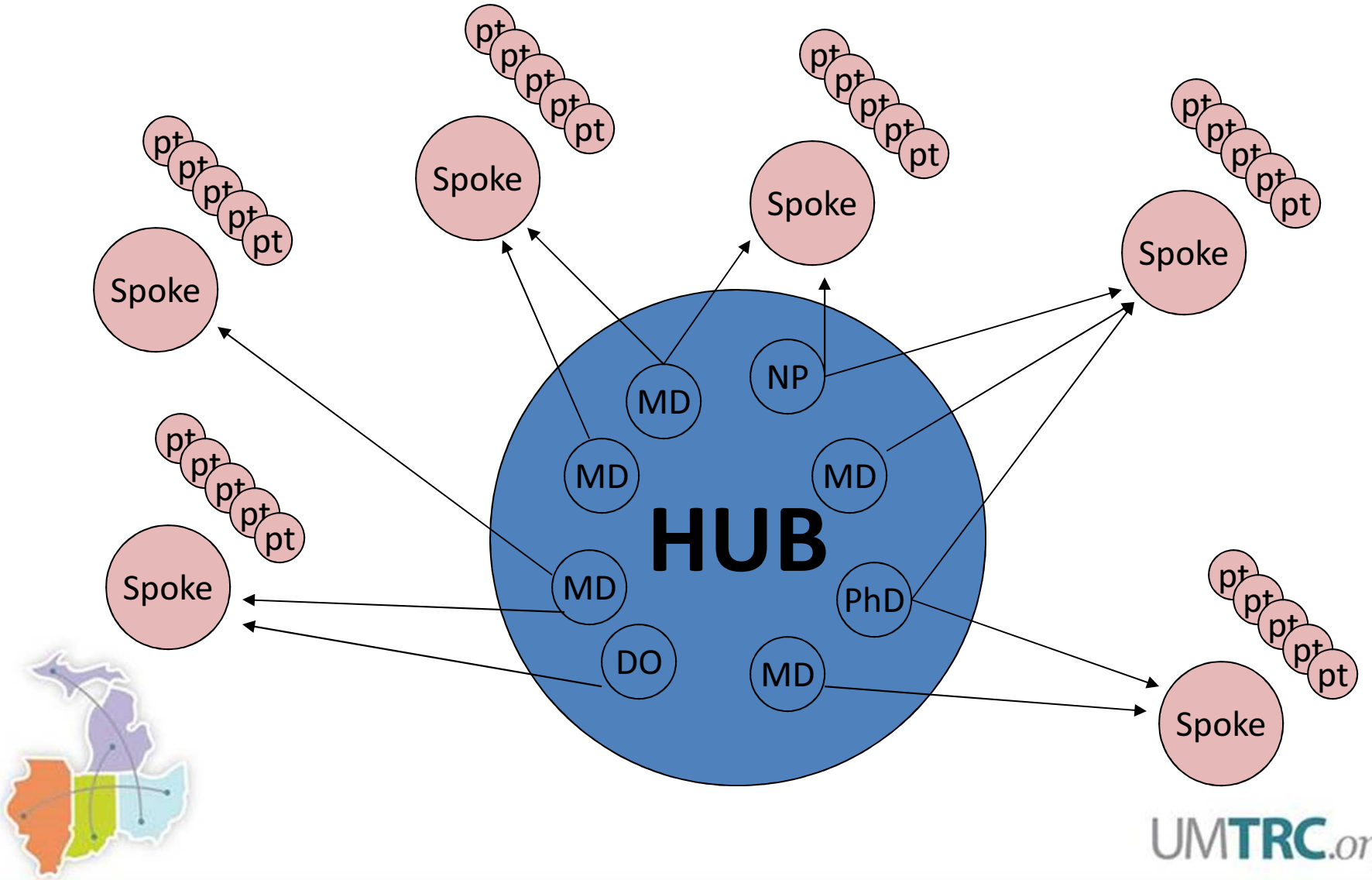
- Providers at the hub
- Patients at the spoke
- Spoke receives <u>services</u>
- Hub receives <u>payment</u>
- Examples: Specialty Consults, MH in ED


ARIZONA TELEMEDICINE NETWORK
ARIZONA TELEMEDICINE PROGRAM
Flagstaff
Phoenix
Yuma
Tucson
NEW MEXICO
Legend
Regional Network Access Point
Active ATP Member Site
Pending or Planned Site
Active Circuit
Pending or Planned Circuit
DS1 (T1) Single or Multiple
DS3 (T3)
Wireless
VPN
Modem
Node Color Legend
Arizona Telemedicine Program Site
Arizona Department of Corrections (ADC)
Pima County Institutional Health
Arizona Department of Health Services
Educational Site
Navajo Area Indian Health Service
Affiliate Network with number of locations

The Peer-to-Peer Model

- In P2P, “spoke” sites develop their own telehealth capacity with available resources
  - Equipment – Inexpensive; capital or grant funds
  - Support – National Telehealth Resource Centers
- These “peer” sites develop the network to meet the mental health needs of their rural clients
- Sustainability through clinical billing alone
- Growth through P2P collaboration, innovation

Hub and Spoke Telemedicine



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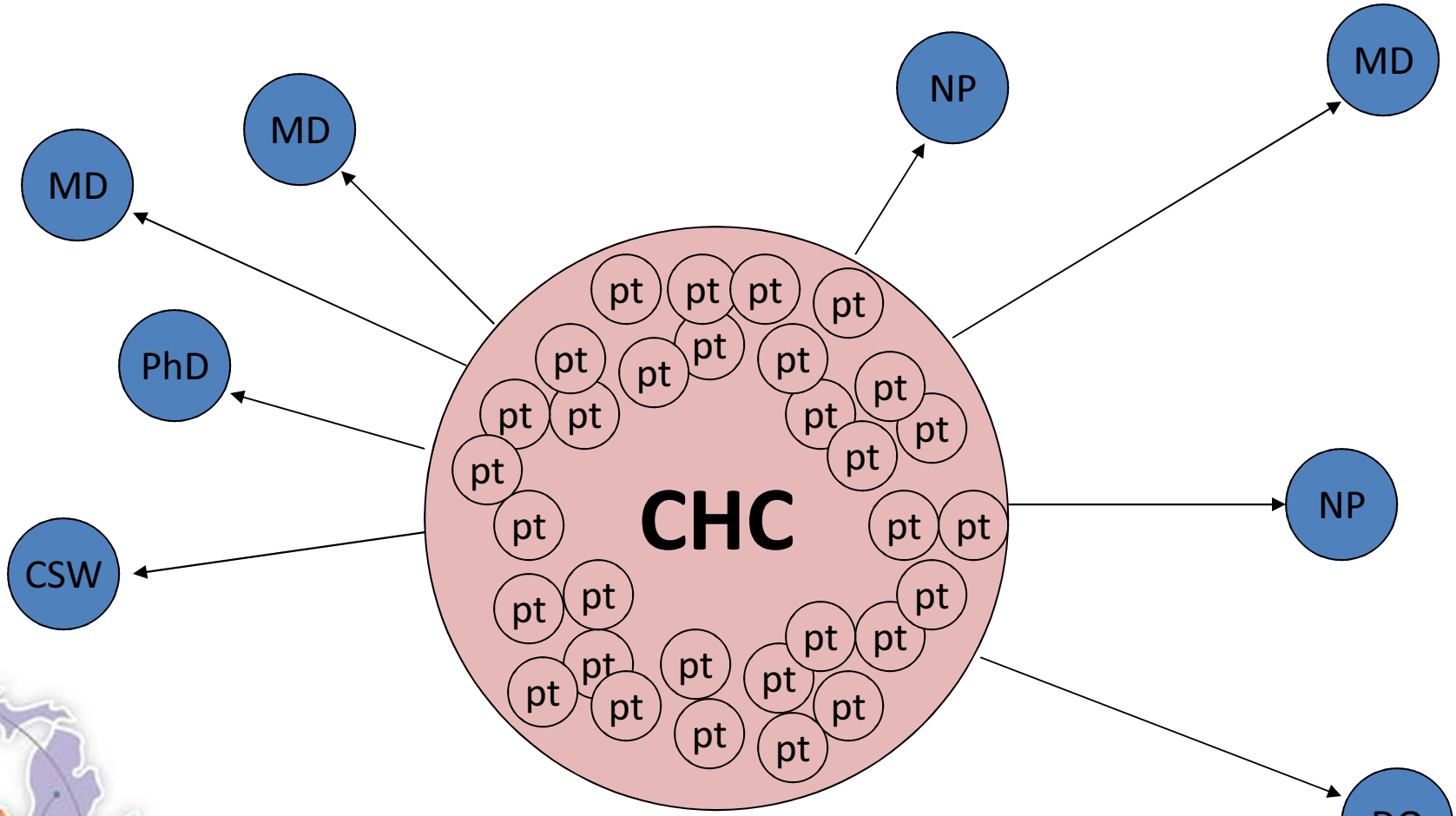
Peer-to-Peer Telemedicine



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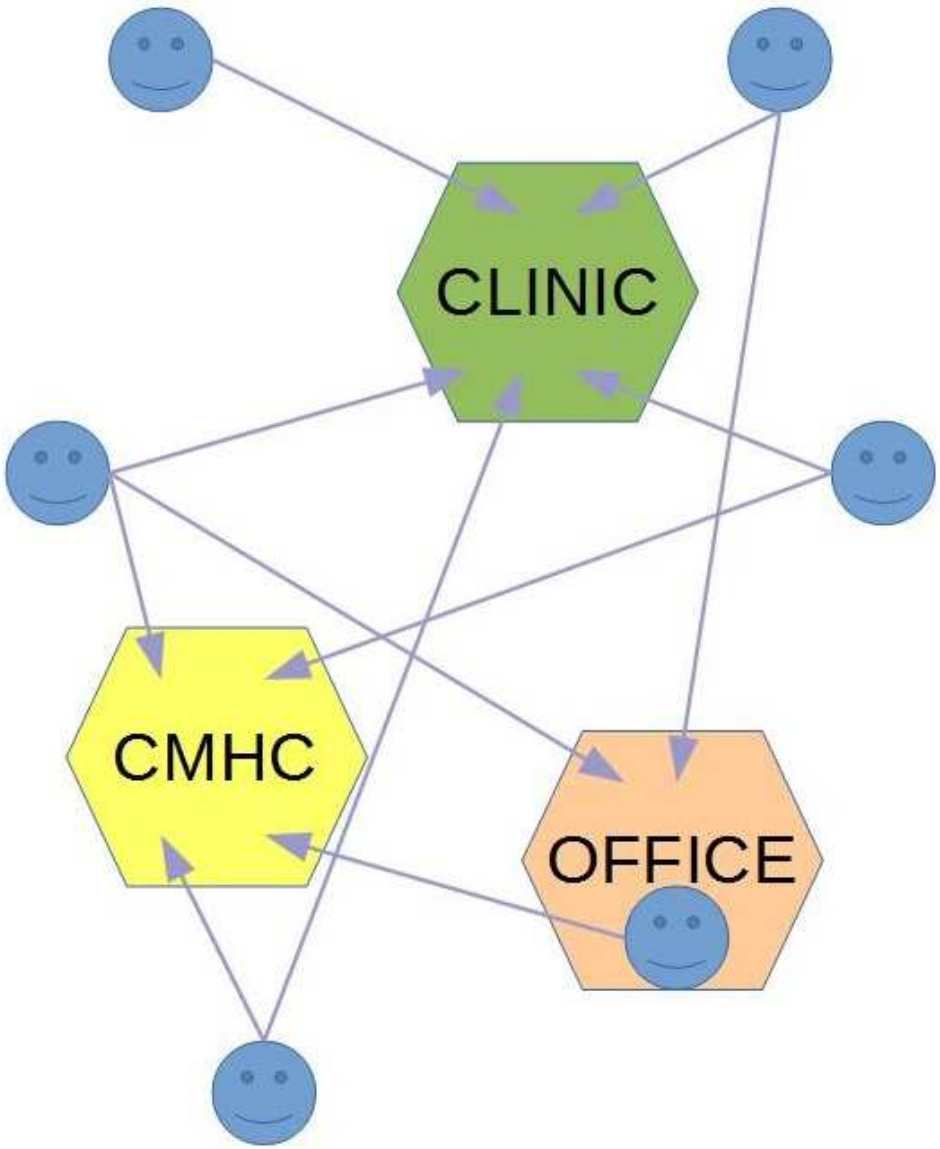


- Clinicians anywhere
- Patients anywhere
- Patient site bills, receives payment
- Clinician gets paid by patient site (as an employee/contractor)
- “Telecommuting” (Indiana & Illinois)

P2P Network(s)

- 3 CMHC
- 1 RHC
- 2 FQHC
- 1 LTC (plus MD/NP site)
- 2 CAH
- 1 Admin (Grantee)

P2P – Putting the Clinic in Charge

- Rather than connecting with a large health system, CHCs can hire/contract directly with the clinicians/services they need
  - CHC drives the project
  - CHC chooses clinicians/services/format
  - CHC bills for services
  - CHC pays clinician
- CHC maintains ownership/control

Indiana Medicaid Provider Manual

- Provider Manual, Chapter 8, Page 8-141 (http://provider.indianamedicaid.com/ihcp/manuals/chapter08.pdf)
- In any telemedicine encounter, there will be the following: (1) a hub site, (2) a spoke site, (3) an attendant to connect the patient to the specialist at the hub site, and (4) a computer or television monitor to allow the patient to have real-time, interactive; and face-to-face communication with the hub specialist/consultant via interactive television (IATV) technology. Services may be rendered in an inpatient, outpatient, or office setting.

Limitations of Services

- Services are limited by 405 IAC 5-38-4(5)
  - Excludes some provider types and services such as ambulatory surgical centers; outpatient surgical services, home health agencies/services, radiological services and laboratory services.
  - For a complete list of excluded services see the Provider Manual.

Conditions for Payment

- HUB and SPOKE are greater than 20 miles apart
    - This will end some time in 2014. A State Plan Amendment has been submitted for approval.
- The member must be present and able to participate in the visit
- The technology must meet the needs of the HUB site physician

HUB Billing Requirements

- Site Services
  - Consultations: 99241 – 99245 and 99251 – 99255
  - Office/Outpatient Visits: 99201 – 99205 and 99211 – 99215
  - Psychotherapy: 90832 – 90840
  - Psychiatric: 90791 and 90792
  - ESRD: 90951 – 90970
- Use Modifier GT to denote telemedicine services

SPOKE Conditions of Payment

- SPOKE may bill for SPOKE services (originating site facility fee)
  - except for FQHCs and RHCs
- In addition, SPOKE may bill for medically necessary evaluation and management
  - Adequate document must be maintained and is subject to postpayment review

SPOKE Billing Considerations

- Bill HCPCS Q3014 with the GT modifier
- Revenue code 780 (telemedicine services)
- If multiple services were provided on the same date as the SPOKE service, bill Q3014 as a separate line item from other professional services

Documentation Standards

- Documentation must be maintained at the HUB and SPOKE sites to substantiate services provided
- Appropriate consent from the member must be obtained by the SPOKE and maintained at both HUB and SPOKE
- Must indicate services were rendered via telemedicine
- Written protocols must exist for when the member must have a hands-on visit with the consulting provider
- Member should always be given the choice between a traditional visit versus a telemedicine visit
- All other IHCP documentation guidelines apply

Other Considerations

- A member should be seen by a physician for a traditional clinical evaluation at least once a year
  - Or as stipulated in policy (planned alternative arrangement)
- HUB physician should coordinate with the patient's primary care physician
- Existing limitations for office visits, third-party liability, spend-down, managed care, and all other considerations apply
- For ESRD services, IHCP requires at least one monthly traditional visit for ESRD-related services to examine the vascular access site

FQHCs and RHCs

- Federally Qualified Health Centers (FQHCs) or rural health clinics (RHCs) are reimbursed only for hands-on services **and are therefore not permitted to bill for telemedicine services**
  - Cannot bill for either HUB or SPOKE services
  - If a face-to-face encounter also occurred during the visit then an encounter can be billed
  - FQHCs and RHCs may submit claims to an MCE as fee-for-service and receive reconciliation review

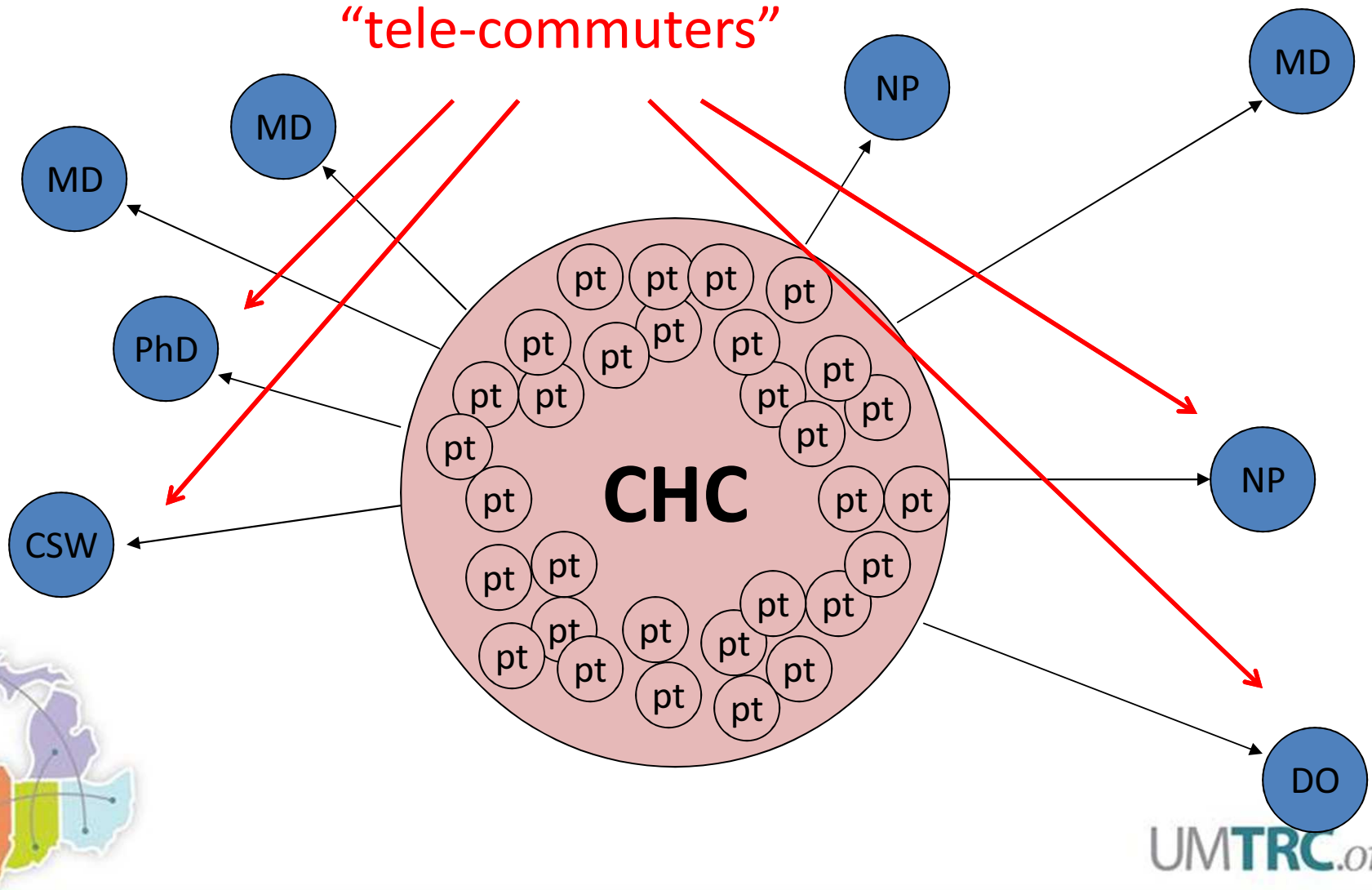
Telecommuting Option

- Has always been available
- Is **NOT** considered Telemedicine
- Does not require HUB or SPOKE
  - An agreement between an employer and an employee or contractor
- There is only one billing entity
  - The FQHC/RHC bills as for any valid encounter
  - The provider does not bill as they are an employee/contractor of the FQHC/RHC
- **No Bulletin or Banner will be issued, nor will the Provider Manual be updated as there is no change from current policy**

Some Important Considerations

- Assumes all of the following are true:
  - The physician is contracted by the FQHC and compensated for the services under a contractual arrangement ("under agreement"). 42 CFR 491.9
  - The services must be "physician" services. 42 CFR 405.2412
  - Services rendered are covered by the Medicaid program and have a valid HCPCS code on the list of recognized encounter codes
  - The FQHC bills the Medicaid program for the service (and the provider does not)

Peer-to-Peer Telemedicine



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Integrated Primary Care

On Site MH (or other) Services

Equipment

- Standard Video End Point ($5,000)
  - LifeSize Passport
  - 32” HDTV (monitor + speakers)
  - Desktop stand or rolling cart
- Web-based System ($1,500)
  - Software (Zoom, Vidyo, etc.)
  - Mini computer + HD webcam
  - 26-32” HDTV monitor + speakers
  - Desktop stand or rolling cart

Equipment

- Web-based System ($500)
  - All-in-one desktop computer
  - HD webcam
  - Software package

Examples of Success

- Models
  - Remote Hiring
    - Specialty Services
    - Core Providers
  - Provider Extending
    - Virtual Travel
      - Clinic sites
      - Nursing and Group Homes (?)

Remote Staffing

- Recruit from anywhere to anywhere
- Retain staff when they move
- Requires new admin skills, flexibility
- Key consideration: Licensure
  - Care occurs at patient site; provider must be licensed to practice in patient's state

What is meant by “undefined”?

- The arrangement is compliant with all applicable regulations, but is clearly not what the regulations expect
- Both the spirit and letter of the law are upheld, but not in the way the law describes or recognizes
- Guidance from CMS and HRSA has been rare, generally conservative, and sometimes equivocal

Medicare Statute Language

- (A) DISTANT SITE.—The term "distant site" means the site at which the physician or practitioner is located at the time the service is provided via a telecommunications system.
- (A) DISTANT SITE.—The Secretary shall pay to a physician or practitioner located at a distant site that furnishes a telehealth service to an eligible telehealth individual an amount equal to the amount that such physician or practitioner would have been paid under this title had such service been furnished without the use of a telecommunications system.

Two Types of Direct Hiring

Wholesale:

- Direct recruitment and hiring
- Two-party agreement (employ/contract)

Retail:

- Third party recruiting/staffing company

Key to Success:

- Continuity of relationship with the tele-provider (for both staff and patients)
- Make them part of your staff!

Example – Oaklawn (CMHC)

- Service locations in Goshen, Elkhart, and South Bend (2 counties)
- 2+ hours from Chicago; 3+ from Indy
- Established 3 telemedicine clinic sites and 3 provider home offices
  - Home offices designed for best effect
  - 2 in Chicago, 1 in Indianapolis
  - Chicago providers do on-site clinics also

Example – Valley Professionals (FQHC)

- Service locations in Vermillion and Parke Counties
- Mental health (psychiatry)
  - Could be used for any provider
  - Clinicians can see patients at multiple sites
- Requires change of scope (but not PPS)

Example – Capabilities Clinic (RHC)

- Service locations in Marion
- Wanted specific mental health services for its target/core population of developmentally disabled adults
- Also opened clinic to the public
  - Psychiatrist and Nurse Practitioner contracted to “telecommute”
  - ~4 hours/wk, scheduled onsite

Key Factors That Drive Success

- Clear Vision (with a sustainable model)
- Technological Openness
  - "Can we meet by video?"
- Integrity & Trust
- Good Information (rules, systems, etc.)
- Solid Partners & Partnerships
- Testing and Rehearsal (per Schedule)

Other Factors Than Contribute

- Stable Internet Connectivity
  - 3 Mbps, cable or fiber, unshared (ideal)
- Right-sized Technology
- Procedural Flexibility/Creativity
- Basic Planning and Follow Through

Process

- Team Development
- Needs Assessment
- Readiness Assessment
- Program Development/Implementation
- Testing and Evaluation
- Expansion (back to the top)

QUESTIONS

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