



ACAP Fact Sheet

Safety Net Health Plans Deliver Better Care and Increase Access via Telemedicine

Summary

The Affordable Care Act has dramatically expanded coverage to people who were previously uninsured or underinsured. However, health insurers must now meet the needs of these newly-covered individuals and families, including assuring access to specialty care. One strategy that insurers—including ACAP-member Safety Net Health Plans¹ (SNHP)—have employed is the use of telemedicine. Telemedicine can help expand access to needed care, facilitate better care coordination and help contain costs.

This fact sheet profiles the efforts of five SNHPs to deploy telemedicine to meet the needs of a growing member base. These initiatives cover a wide range of services and approaches, including increasing access to child psychiatry, connecting members in rural counties to specialists, using electronic referrals to enhance communication between providers, and leveraging telemedicine to better integrate physical and mental health.

Background

In the United States the number of patients per primary care physician is increasing; more providers are preparing to retire while both an aging population and an increase in the number of individuals obtaining coverage under the ACA increase demand.² Shortages are no longer limited to primary care doctors; by 2020 there will be a deficiency of an estimated 46,100 specialists and surgeons in the United States.³ This decrease in supply will only exacerbate provider shortages that exist today, especially in rural communities, and contribute to escalating health care costs. In response to these constraints, Safety Net Health Plans have looked to telemedicine as a potential solution.

Telemedicine⁴ leverages technology to coordinate care and extends the settings in which care can be delivered. Telemedicine can take place through a video conference, over the phone, or through

¹ ACAP defines a “Safety Net Health Plan” as a local, community affiliated non-profit health plan that derives 75 percent or more of its gross revenues from government programs that target low-income, elderly or disabled populations. Congress has acknowledged the special nature of many of these plans by exempting them from the health insurance plan excise tax.

² Association of American Medical Colleges, “Physician Shortages to Worsen Without Increases in Residency Training.” <http://bit.ly/1yAzOyL>. Accessed November 5, 2014.

³ Gallegos, Alicia. “Medical Experts Say Physician Shortages Goes Beyond Primary Care.” Association of American Medical Colleges. February 2014. <http://bit.ly/10vkXHj>. Accessed November 5, 2014.

⁴ Also known as “tele-health,” but referred to as “telemedicine” throughout this paper.



electronic messaging, including images, test results and other data.⁵ Consultations can take place between a doctor and a patient, or between two or more doctors. Telemedicine can help patients who live in areas with few specialists get the care they need more quickly or more conveniently, sparing them a long trip. It can also help specialists with heavy caseloads dispense care more efficiently, providing consults to primary care physicians (PCPs) and providing direct access for patients with more complex needs. This increased coordination not only addresses access problems; it also can help bend the cost curve.

Safety Net Health Plans are well-positioned to be at the forefront of telemedicine because of their unique and intimate relationships with the communities they serve. A survey of ACAP-member SNHPs found that more than half reimbursed for services delivered through telemedicine.⁶ However, many plans may be limited in their use of telemedicine, or decline to use it altogether because of state requirements. For example, only twenty states specifically authorize Medicaid managed care organizations' use of telemedicine.^{7,8}

Because telemedicine has a vast scope, policy makers have taken various approaches when governing the industry including regulating:⁹

- **Patient and provider settings:** the patient's location, or the "originating site," and/or the location of the provider offering care or consultation, or the "distant site;"
- **Allowable provider types** (e.g., psychiatrists);
- **Eligible technology and services** (e.g., videoconferencing or remote monitoring);
- **Distance or geography standards** (e.g., requiring a patient to live in a rural setting to receive services via telemedicine);
- **Requirements that another certified individual**, or telepresenter, be present with a patient during a telemedicine visit; and
- **State licensure requirements** that require providers to be licensed in the state which they are delivering telemedicine services.

Despite certain policy hurdles, SNHPs are using telemedicine to develop new and innovative models for delivering care. Five profiles follow detailing how SNHPs use telemedicine to increase access, better coordinate care and contain cost.

⁵ Michele Seslar and Rene Quashie. "Navigating the TeleHealth Landscape." The Advisory Board Company. 2014.

⁶ This survey was conducted in January 2013, with 38 respondents.

⁷ Latoya Thomas, Gary Capistrant. "State Telemedicine Gaps Analysis, Coverage & Reimbursement," American Telemedicine Association. September 2014. <http://bit.ly/1okh39x>. Accessed November 5, 2014.

⁸ Specific authorization does not always preclude SNHPs in other states from offering telemedicine services if broader state regulations permit it.

⁹ Thomas and Capistrant. "State Telemedicine Gaps Analysis, Coverage & Reimbursement."



An Electronic Referral and Consultation System Addresses Access Problems and Facilitates Care Coordination

In response to significant wait times for key specialties, **San Francisco Health Plan (SFHP)** awarded the San Francisco Health Network (SFHN) delivery system a \$1.5 million grant to spread an integrated referral and consultation system. The system, called eReferral, relies on a home-grown electronic application for referrals and consultation which is deeply integrated with SFHN's existing electronic health record (EHR) system.

Physicians submit referrals through eReferral, which are electronically routed to the identified service area or specialty. Each specialty has a dedicated provider—a physician or nurse practitioner—who is responsible for reviewing and responding to referrals within three business days.

Incoming referrals are managed in one of four ways.

- The consult may be **scheduled** for a routine or expedited clinic visit, depending on clinical urgency;
- The consult may be **redirected** to a more appropriate specialty (e.g. diabetes clinic instead of endocrine clinic),
- The consult may require **additional information** – either clinical history or further diagnostic evaluation – before deciding whether to schedule the patient for an in-person visit, or
- The consult may be addressed through a **virtual consultation** entirely within the eReferral system without a scheduled visit.

Although these categories are not unique to SFHN, the eReferral system has allowed specialists to provide care more efficiently by performing a review before a member comes through the specialist's door for an office visit. For example, if a member is referred by their primary care provider to an orthopedic specialist, the clinician reviewer can schedule a specialty consultation through the system and ensure appropriate testing is completed prior to the visit. This reduces the need for repeat visits.

The eReferral system has also helped SFHN's network of specialists maximize their expertise—not merely fill available time on their calendar. A specialist reviewer may find a referral unnecessary because the condition can be managed in a primary care setting; he or she would provide guidance through the system as to how to do so. Primary care providers can use the system to seek advice about, or even co-manage, a member's condition. All of this correspondence between the primary care provider and specialist is iterative, shared in real time, and saved to the member's EHR for future reference.

A lingering question about a system such as this is how reviewers are reimbursed for their time triaging referrals. SFHN is paying their physicians on salary and provides its specialty reviewers salary support for time allocated to addressing incoming referrals within the required three days.



Primary care physician and eReferral Director Alice Chen explained, “Prior to this program, making referrals was like playing tennis: primary care doctors were hitting balls to specialty care and sometimes they would be hit back, but some were stuck in the fence and others were lying in the grass. eReferral is more like a racquetball court: PCPs can see and track all the balls; and more often than not, the ball is in the PCP’s court.”

The result has been an increase in access. Average wait times for initial consultative visits decreased from approximately 116 days to about 45 days in the clinics of nine early adopters.¹⁰ SFHN’s use of telemedicine through their eReferral system has transformed their network, better integrating primary and specialty care and addressing key access concerns.

One Plan Builds Its Own Platform to Integrate Physical and Mental Health

Colorado Access (COA) sees telemedicine as a mechanism to achieve the triple aim - reducing costs, improving health outcomes, and improving the patient experience. Two years ago, they hired a telemedicine expert to develop technology that would engage their membership in a more meaningful way. As a result, this summer COA launched AccessCare Technology and AccessCare Services, two sister organizations that support Colorado Access’s use of telemedicine. AccessCare Technology created the portal on which AccessCare Services are delivered; both are intended to help Colorado Access better integrate behavioral and physical health with hopes of expanding to other disciplines in the future.

AccessCare Technology created a HIPAA-compliant system, named Aveo, which allows for patient-provider and provider-provider consultations through real-time videoconferencing. The videoconferencing is “multipoint,” meaning that multiple providers can converse with a member or amongst themselves at the same time. The technology uses little bandwidth, therefore a broadband Internet connection isn’t required. This makes it ideal for use in rural settings. The platform supports members logging in at a clinic, or even at home. Members will be able to use the dashboard to find providers, schedule video-conferencing visits, and message with their provider(s).

Although the system has this at-home capability, COA’s Medicaid members will not be able to benefit from it because members must be at an approved site to receive services through telemedicine under the rules of Colorado’s Medicaid program.

COA plans to use Aveo to better integrate primary care and behavioral health; its plans call for primary care providers to schedule meetings on behalf of their members with one of AccessCare Services’ behavioral health specialists. Members will be able to visit their primary care doctor and then videoconference with a psychiatrist, psychologist, social worker, clinical counselor, or care manager, depending on their needs.

¹⁰ Alice Hm Chen, M.D., M.P.H., Elizabeth J. Murphy, M.D., D. Phil., and Hal F. Yee, Jr., M.D., Ph.D. “eReferral- A New Model for Integrated Care,” NEJM 368;26, June 27, 2013.



The platform also facilitates the coordination and collaboration between the behavioral health team and the primary care physician. Providers involved in a member's treatment have access to their digital medical records, can converse through chat about a member, and can consult with other providers.

The system and network are still in their infancy, but COA believes that these new services will revolutionize the way in which they deliver care and ultimately realize the goals of the triple aim.

Coordinators Use Telemedicine as a Vehicle to Integrate Mental and Physical Health

Community Health Plan of Washington (CHPW) uses telemedicine as the vehicle to coordinate care as part of its Mental Health Integration Program (MHIP) in the state of Washington. The plan has found telemedicine to be essential to the program's success. As part of the MHIP program, CHPW grants funds to their community health center (CHC) partners to integrate behavioral health coordinators in the primary care clinics. These behavioral health coordinators work closely with the technology, and are central in maximizing its potential.

Coordinators triage members during primary care visits using standard mental health screening tools. They enter the results of these screening tools into a web-based patient registry, the Mental Health Integrated Tracking System (MHITS), which tracks patient progress. Coordinators then meet weekly with a consulting psychiatrist through phone or videoconference. During these consults, specialists can access the MHITS and discuss individual members. Together, the behavioral health coordinator and consulting psychiatrist determine the appropriate level of care for members based on their profiles. Next steps can include brief intervention, continued monitoring, additional screening, or a consultation between the member and the specialist over a secure Webcam connection.

CHPW has expanded this program to address substance abuse through the SAMHSA-funded Washington Screening Brief Intervention and Referral to Treatment – Primary Care Integration (WASBIRT –PCI) grant and has added pain management teleconsults via a grant from the University of Washington. SBIRT and PEG¹¹ are now used in several CHC locations as part of the standard screening process. Coordinators in these participating CHCs use videoconferencing to connect with a consulting psychiatrist specializing in substance abuse and pain through the University of Washington to discuss at-risk members. Like many states, Washington has a shortage of psychiatrists, especially those who focus on substance abuse. Triage care through telemedicine makes the most out of their limited availability and ultimately expands access to their expertise.

CHPW found that specialty referrals decreased over the course of the program. The videoconference consultations helped to increase primary care physicians' comfort level to directly treat and make medication adjustments without a specialist consult. CHPW will continue to use telemedicine to expand access to additional specialties throughout the state and to better integrate care for their members.

¹¹ SBIRT is used to identify and address substance abuse and PEG is a pain measurement tool that measures average pain intensity, the pain's interference with enjoyment, and interference with general activity.



Videoconferencing Pilot Connects Rural Northern Californians to Specialists

Partnership HealthPlan of California (PHC) is a non-profit community-based health care organization that contracts with the State to administer benefits in 14 counties through local health care providers to serve more than 473,000 Medi-Cal recipients. In 2013, PHC expanded its service area by adding eight additional counties in northern California: Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou and Trinity. These counties are largely rural. Partnership HealthPlan leaders met with local community and health center leaders concerned about access to care and put a plan in motion to offer a multi-specialty telemedicine program to help improve the availability of specialty care to its members. PHC contracted with TeleMed2U, a 100% telemedicine-based, multi-specialty, clinical practice of board-certified physicians who offer specialty care services using real-time audio-visual teleconferencing.

Partnership HealthPlan selected three primary care clinics in three different counties to pilot this telemedicine program. The selected pilot sites were chosen based on previous telemedicine experience, easing and expediting the integration of TeleMed2U specialties into the clinic's daily workflows. Each clinic has implemented one specialty to start with. Once operational testing is complete and any issues are addressed, additional specialties will be added. Two pilot sites have started with endocrinology and the third site with hepatitis C.

TeleMed2U and PHC have worked with each individual site to conduct implementation meetings to plan the roll out of each specialty and discuss the processes that need to be in place for successful clinical sessions. Weekly testing schedules are in place at each clinic to ensure any equipment used to connect the patient to a TeleMed2U specialist is working properly and the connection is of sufficient quality to have a successful consultation.

The pilot is still relatively new and quantitative clinical data is not yet available, but PHC already sees a positive difference in surveys of patients who have benefited from the program. The telemedicine pilot is still in the early stages, with additional health center sites being on-boarded monthly to expand telemedicine consultative service in additional counties and increasing specialty care access to PHC's members. PHC doesn't consider telemedicine as the single solution to access to care issues in its network. Instead, the plan sees telemedicine as another means to provide members with options and incremental improvement in the timeliness and quality of care that they receive.

Working to Address Child Psychiatric Needs while Navigating Telemedicine Policy

Driscoll Health Plan is a Safety Net Health Plan serving more than 100,000 members in South Texas. Most of its members are children. The plan faces a severe shortage of child psychiatrists; in Driscoll Health Plan's service area, there is roughly one child psychiatrist per 100,000 children. To address this shortage, Driscoll Health Plan worked with the University of Texas Medical Branch at Galveston to increase access to child psychiatrists through tele-psychiatry.



Under this initiative, members go to a local mental health center and consult with a psychiatrist via telemedicine. Member participation is high; the no-show rate is below 10 percent. Surveys of members indicate high levels of satisfaction with the program. Providers support the program, too, because it helps to alleviate the demand for behavioral health services.

Like many states, Texas requires telemedicine visits to be conducted by a provider licensed in their state. And Texas faces a shortage of state-licensed child psychiatrists—even with telemedicine, there are not enough child psychiatrists to meet demand. Driscoll Health Plan continues to recruit child psychiatrists to their service area and into their telepsychiatry program, but the shortage persists.

Despite these promising signs, DHP's telemedicine initiatives have been constrained by their local Drug Enforcement Agency (DEA) office's guidance on the Ryan Haight Act. The Act governs the distribution and dispensing of controlled substances through the Internet and includes specific exemptions for telemedicine. Clarifying regulations regarding the use of telemedicine have not been finalized, leaving interpretation and enforcement to the local branches of the DEA. The DEA branch for the Driscoll Health Plan service area has issued guidance that prohibits physicians from writing prescriptions for controlled substances through telemedicine, unless the patient has first been seen in a face-to-face visit. The DEA will grant an exception if the patient site has a DEA license. However, the local mental health authorities have been unsuccessful thus far in their efforts to obtain this license.

This interpretation has effectively shut down some telemedicine programs, and severely hampered Driscoll Health Plan's telepsychiatry efforts given that many members needed prescription medication that may be a controlled substance to treat behavioral health related conditions, such as ADHD.

Without a statutory or regulatory fix, this may severely hamper the efforts to use telemedicine to improve access to needed psychiatric care for children.

Lessons Learned

- **Telemedicine can be an invaluable source of primary care education.** Plans were nearly unanimous in their praise for telemedicine as a source of continuing education for their primary care physicians. When telemedicine occurs in the primary care setting, PCPs can learn through observing how specialists deliver care to their patients. Plans using telemedicine find the number of referrals to specialists decrease because knowledge is being transferred from specialists to the PCPs. This helps PCPs manage more conditions in the primary care setting and enables participating providers to deliver services at the top of their license.
- **Effective telemedicine programs help to further integrate services.** The most successful telemedicine programs do more than provide a means to specialty care; they integrate the specialty services into the primary care setting. This integration takes time and coordination on both the part of the PCP and the consulting specialist. Telemedicine makes this easier but dedicated resources such as coordinators can help facilitate this integration.



- **Reimbursement can be a major hurdle to telemedicine adoption.** Many reimbursement schedules were developed before telemedicine took off as a practice, and have not been updated to reflect changes in current technology, the attendant administrative work, or overhead costs. To improve uptake rates for telemedicine programs among their in-network providers, SNHPs have taken creative approaches to reimbursement because they have realized overcoming this barrier is key to a successful telemedicine program.

Policy Issues

Although telemedicine holds great promise as a way to expand access to needed care, several policy issues have surfaced that may impede broader adoption of telemedicine as a means to improve access. Suggested solutions to these impediments for policymakers to consider follow.

First and foremost, state Medicaid regulations and contracts should grant Medicaid managed care plans sufficient flexibility to implement telemedicine programs. The health plans described above were able to develop their programs because regulatory and contractual requirements allowed for it. All Medicaid managed care plans should be granted this opportunity. Moreover, individuals with Medicaid coverage should have access to the same available benefits as those with commercial insurance. For example, in Colorado those with commercial coverage can access telepsychiatric services at home, while Medicaid members cannot.

Second, providers available through telemedicine are an extension of an insurer's provider network and should be counted as such for the purposes of any network adequacy requirements. In addition, requirements that telemedicine can only be provided in rural areas of a state are antiquated and should be updated. Provider shortages in certain specialties are no longer only limited to rural communities.

Third, costs associated with necessary coordination activities in telemedicine programs should be considered as a medical expense under any state-imposed Medical Loss Ratio (MLR) requirements. These costs are an integral part of the telemedicine visit and should not be categorized as administrative in nature.

Other considerations would include policies to facilitate the licensure of providers in multiple states, while still assuring adequate protections and public safety. One solution could be medical license reciprocity arrangements between multiple states. These policies could help alleviate access issues in states suffering from a short supply of specialists, such as child psychiatrists in Texas.

Finally, there must be a meaningful review of how statutory and regulatory decisions will affect telemedicine. For example, limiting the ability of a telemedicine provider to prescribe medications may impede the viability of telemedicine as a mechanism to extend access to care. Where appropriate, policymakers should look at telemedicine videoconferencing as an extension of services delivered in person.



The use of telemedicine is not new. The preponderance of evidence shows that it is an effective means of delivering care while receiving high patient satisfaction results. While quality and patient safety are paramount concerns, greater regulatory flexibility, would allow for innovative telemedicine solutions that would further drive our health care system towards the triple aim.

Conclusion

Safety Net Health Plans are leveraging telemedicine to assure their members have access to quality health care while being good stewards of public resources. While telemedicine holds great promise for expanding access, some policies can impede its widespread adoption. It is important that policymakers find a balance in creating rules that allow for innovative solutions to provider shortages while at the same time ensuring these programs are safe, appropriate and effective.

The Association for Community Affiliated Plans (ACAP) is a national trade association representing 58 not-for-profit Safety Net Health Plans in 24 states. ACAP's mission is to strengthen not-for-profit Safety Net Health Plans in their work to improve the health of lower-income and vulnerable populations.

Collectively, ACAP-member plans serve nearly twelve million enrollees, representing more than 50 percent of individuals enrolled in Medicaid-focused health plans.