A Virtual Reality for Texas

Mike Siegel
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Agenda

➢ Texas legislative update and impact to stakeholders

➢ Overview of policies from other regulatory bodies

➢ Strategic implications

➢ Clinical use cases

➢ Potential telehealth partners
Texas S.B. 1107

- Allows patient-physician relationships to be established virtually; including both live audio-video and asynchronous (store-and-forward) platforms.

- Prohibits an agency with regulatory authority over a health professional (e.g. TMB) from adopting rules pertaining to telehealth services that would impose a higher standard of care than the standard described by the bill.

- Removes the authorization for the Texas Medical Board to adopt rules as necessary to define situations when a face-to-face consultation with a physician is required after a telemedicine service.

- Specifies that a health benefit plan may not exclude a covered health care service or procedure delivered by a preferred or contracted health professional to a covered patient as a telemedicine medical service or telehealth service solely on the basis of the service or procedure not being provided in person.

- Excludes mental health services from statutory provisions governing telemedicine and telehealth.

Commercial Reimbursement

➢ S.B. 1107 bolsters Texas’ telemedicine parity law

➢ Discussing results or reviewing images can be reimbursed if done so with approved technology platforms
  • For example, remotely reading a patient’s glucose is eligible for reimbursement with a maximum of once every 7 days

Updated Texas Medical Board Responsibilities

➢ Ensure that patients using telemedicine receive appropriate, quality care

➢ Prevent fraud and abuse in the use of telemedicine, including rules relating to the filing of claims and records required to be maintained in connection with telemedicine encounters

➢ Provide adequate supervision of health professionals who are not physicians and who practice telemedicine (i.e., physician assistants and nurse practitioners)

➢ Jointly develop specific rules for prescriptions issued through telemedicine encounters (in conjunction with Texas Board of Nursing and Texas Board of Pharmacy)
Medicaid Requirements

➢ Patient-Site Presenter
  ➢ Similar to previous Texas Medical Board requirements
  ➢ Must be enrolled as a Texas Medicaid provider
  ➢ All patient sites must maintain documentation for each service including:
    • Date of service
    • Name of client
    • Name of distant-site provider
    • Name of patient-site provider
  ➢ Patient-site providers may only be reimbursed for the facility fee using procedure code Q3014. Procedure code Q3014 is payable to NP, CNS, PA, physicians, and outpatient hospital providers.
Medicaid Requirements

➢ **Distant-Site Provider:**
  - Physicians (MD, DO, DPM, DDS, DMD, OD, DC)
  - Physician Assistant
  - Nurse Practitioner
  - Clinical Nurse Specialist
  - Certified Nurse-Midwife
  - (those excluded are considered “telehealth” providers”)

➢ Must be enrolled as a Texas Medicaid provider

➢ Patient must receive **in-person** evaluation for same diagnosis or condition before receiving telehealth service
Medicaid Reimbursement

➢ There is parity

➢ Remote Patient Monitoring: Procedure code is limited to once per 7 days
  • Setup and daily monitoring is reimbursed when provided by home health agency or outpatient hospital (prior-auth required)

➢ Distant site providers must use the “95” modifier except when service indicates remote delivery (originating site can bill for facility fee)

➢ SB 922 – Schools can now be reimbursed even if the provider is not the patient’s existing provider (pending parental consent)
  • Example: A speech pathologist serving 8 schools, spread out in rural communities, can now use telemedicine (school is the provider)

➢ SB 1633 – Allows pharmacist to supervise remote pharmacy intern or tech at a “remote dispensing site” – similar rural requirements to Medicaid
Medicare Requirements

➢ There is parity

➢ Medicare beneficiaries are eligible for telemedicine services only if presenting from an originating site located in:

- A rural Health Professional Shortage Area (HPSA) located either outside of a Metropolitan Statistical Area (MSA) or in a rural census tract; or
- A county outside of an MSA
- Entities participating in a Federal telemedicine demonstration project
Medicare Requirements

➢ Originating site (or “patient site”) defined:
  • The location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs
  • Medicare does not require a medical professional to be present unless medically necessary, as determined by the distant site provider

➢ Authorized originating sites include:
  • Office of physician or practitioner
  • Hospital (inpatient or outpatient)
  • Critical access hospital
  • Rural health clinic
  • Federally qualified health center
  • Hospital-based or critical access hospital-based renal dialysis center
  • Skilled nursing facility
  • Community mental health center
Medicare Requirements

➢ Distant site practitioners include:
  • Physicians (MD, DO, DPM, DDS, DMD, OD, DC)
  • Physician Assistant
  • Nurse Practitioner
  • Clinical Nurse Specialist
  • Certified Registered Nurse Anesthetist
  • Certified Nurse-Midwife
  • Clinical Social Worker
  • Clinical Psychologist
  • Registered Dietician or Nutrition Professional
Medicare Telehealth Parity Act of 2017

Currently Eligible Sites
- Office of physician/practitioner; CAH; SNF; Hospital/CAH based Renal Dialysis Center; Community Mental Health Center

All FQHCs & RHCs

Home Health Site

Current Law
- Rural HPSA
- Non-MSA County
- Federal Demonstration

Phase 1
- (6 months after enactment)
- County within MSA of <50,000

Phase 2
- (2 years after enactment)
- County within MSA of >50,000 BUT <100,000

Phase 3
- (4 years after enactment)
- County within MSA of at least 100,000

These sites will be eligible as originating sites in all of these geographical areas.

FQHCs & RHCs will not be subject to geographical restrictions.

Added as eligible site/no restrictions.

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Other Regulatory Progress

➢ Veterans Health Administration deregulation

Photo: Evan Vucci, AP
Expanding Virtual Health

➢ Launched in 2012
➢ $400 million investment
➢ 59 million virtual visits in 2016 (52% of total patient visits)
Expanding Virtual Health

Imagining Care Anywhere

HOME ENVIRONMENT

Gina’s care team is assembled for the virtual consultation: her doctor, dietician, wellness coach and nurse.
Strategic Opportunities
Develop a Preferred Telehealth Network for Employee Health Plans

➢ Target the offering towards existing patient-physician relationships through local 501a
  • Primary care follow-up visits
  • Chronic disease management
  • Surgical pre-/post-op visits
  • New prescriptions, adjustments and refills
  • Beneficiaries located in other markets

➢ May also include other Tier 1 or affiliated providers
  • Specialty care not offered domestically or even locally
  • Urgent care visits

➢ Employee benefit and physician reimbursement models would follow those of the corresponding EHP network tier
Commercialize Your Telehealth Network for Payers or Self-Insured Employers

➢ Target regional self-insured employers, offering local system providers as narrow networks, with the preferred telehealth network as a second tier

➢ Could be offered through direct-to-employer arrangements; or through health plan partners; or as a separate commercial offering to employers

➢ May encompass a range of reimbursement models, depending on type of offering:
  • Included in Tier 1 or Tier 2 benefit for direct employers
  • Network access fee to health plan partners
  • Per visit, subscription or PMPM to employers
Employer-Based Telemedicine

Trends that drive employer-based telemedicine:
• Save Money
• Save Time
• Timely Healthcare
• Employee Engagement

Healthcare Visits for 50-Employee Organization

<table>
<thead>
<tr>
<th></th>
<th># of visits replaced</th>
<th>Savings per visit</th>
<th>Savings</th>
<th>Total Savings</th>
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<tbody>
<tr>
<td>Emergency Room (ER)</td>
<td>4</td>
<td>$850/visit</td>
<td>$3,400</td>
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<tr>
<td>Urgent Care</td>
<td>10</td>
<td>$150/visit</td>
<td>$1,500</td>
<td></td>
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<tr>
<td>Doctor’s Office</td>
<td>32</td>
<td>$85/visit</td>
<td>$2,720</td>
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<tr>
<td>Time Off</td>
<td>45 Emp x 4 Hours</td>
<td>$20/hour</td>
<td>$3,600</td>
<td></td>
</tr>
<tr>
<td>Loss of Productivity</td>
<td>45 Emp x 4 Hours</td>
<td>$45/hour</td>
<td>$8,100</td>
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</table>

Reference: https://www.edochome.com
Telemedicine in Schools

Case Study

Schools: 12

Students: 6,820

District Rank, by Size:
138th in Texas

Telehealth Service Launch:
Fall 2014 Lewisville ISD

Schools In Telehealth Network: 9

Students: 6,491*

* mix of elementary, middle and high schools

➢ Average family savings per encounter: 3.4 hours of work time, $177 in ER, $54 in physician’s cost
➢ Travel savings per encounter $101-$224

Positive Evaluations from School Nurses and Parents

91% of parents and guardians were satisfied with the telemedicine program

Nearly 4000 children have accessed clinical telehealth.

66% of these children, reported by school nurses, would otherwise have visited emergency rooms or urgent care centers, costing $1,023, which is 6 times more than the telehealth visit.

$1,023*

$160

*average cost of top four telehealth diagnoses

Reference: https://www.childrens.com
Utilize Your Telehealth Network to Improve Quality Outcomes and Control Costs under Medicare Advantage

➢ Medicare regulations for telemedicine are very restrictive
  • Rural / HPSA Communities
  • Federally-Qualified Health Centers
  • ~ 1% of beneficiaries using telehealth
  • Next-Gen ACOs are exempt from Medicare’s geographic restrictions on telehealth
  • CHRONIC Care Act of 2017 would relax restrictions for MA enrollees and ACO lives

➢ Telehealth utilization under Medicare Advantage is growing rapidly but still relatively small

➢ Recent federal legislation suggests interest in telemedicine
  • MACRA
  • ECHO Act
  • 21st Century Cures Act
  • National Defense Authorization Act for FY 2017
Medicare Advantage

Figure 1: Example of Telehealth Use in Medicare

Live audio-visual communication between provider and patient

Provider at distant site

Distant site submits claim for service provided

Medicare claims processing

Originating site submits claim for $25 facility fee

Patient at originating site

Source: GAO analysis of Medicare statute and regulations. | GAO-17-365
Clinical Use Cases
Diabetes Management

➢ A patient with severe diabetes might require 8 visits per year
  • Blood sugar readings
  • Blood pressure measurement
  • Weight
  • Eye exams
  • Foot exams
  • Labs
  • Nutritionist visits
  • General checkups
  • Insulin adjustments

➢ Initially, at least half of these visits can be replaced with virtual visits and remote patient monitoring (RPM)

➢ Consider leveraging an additional platform to integrate remote patient monitoring into the patient’s electronic health record
  • Physician can read remotely and intervene when necessary
  • Research shows patients check glucose more frequently
Chronic Care Management - Diabetes

Process flow diagram for managing diabetes through telemedicine

CCM = Chronic Care Management
Who?
- Employees diagnosed with diabetes
- Enrolled in Employer’s health plan for last 3 years

How Many?
- 179 potential participants
- 7 excluded due to major health issues besides diabetes
- 141 elected to enroll
- 71 used the program by transmitting readings

### Initial Onboarding
- Initial Shipment of Supplies
- Care Specialist Walkthrough
- Register Online

### Compliance
- Care Specialists encourage/educate participants who fail the test

### Alerts
- Within minutes of dangerously low readings, Care Specialists can triage to suggest remedial actions.
- Care Specialists can focus on adherence for patients with chronically high readings

**Pre-Program vs. Post-Program Claims Costs**

Primary Care Follow-Up

- Essential for any outpatient service
- Drive practice revenue
  - Better utilize time and resources of physician and staff
  - Reduce the instances of patient no-shows
  - Virtual visits average 5 minutes and 40 seconds*
- Increases patient satisfaction and retention
- Improve clinical outcomes and ease of access: physicians can use before/after office hours to accommodate more patients and earn extra income

<table>
<thead>
<tr>
<th>Type of visit</th>
<th># of patients</th>
<th>Time</th>
<th>Revenue</th>
<th>Profit Increase</th>
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<tbody>
<tr>
<td>In-Person</td>
<td>4</td>
<td>1 hour</td>
<td>$200</td>
<td>$100 (assuming negligible variable costs)</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>6</td>
<td>1 hour</td>
<td>$300</td>
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</tr>
</tbody>
</table>
Primary Care Follow-Up

Process Workflow

Start

Is the care requested an established telemedicine specialty?

Yes

Obtain signed patient consent form; provide written instructions

Determine type of care:
- Chronic Care Management
- Medication adjustments
- Review of current condition

Provide the care per treatment plan

No

Forward the request to Clinic Supervisor

End

Yes

Immediately schedule face to face visit

No

Is the Condition extreme; urgent attention required?
Pre-Operative Care

➢ Pre-op consultation
➢ Pre-op instructions
➢ Meet with physician via teleconference

➢ Reduces:
  • Patient no-shows
  • Patient burden
  • Surgeon ‘non-productive time’
Post-Operative Care

➢ Many surgeons are not compensated for post-op care
  • By conducting orthopedic post-op visits through video-conference, patient time is reduced from 10-15 minutes to 3-5 minutes

➢ First telemedicine appointment is scheduled on day of discharge
  • Allows for remote patient monitoring from surgeon, anesthesiologist, PCP
  • Gives patients the opportunity to more easily connect with the care team

➢ Follow-up visits generally include:
  • General Wound Care
  • Pain, infection, bleeding
  • Nutrition
  • Drug dosage adjustments
  • Biopsy reports
  • Long-term planning and follow-up
  • Any other visual follow-up relating to a specific surgery
Telemedicine Platforms

- eVisit
- CHIRON HEALTH
- glooko
- Vidyo
- AZOVA
- Dr onDEMAND
- TELADOC
- AdvancedMD
- Zipnosis
- MDLIVE
- vivifyhealth
Telemedicine Platforms

Why Is Telemedicine So Important?

➢ Texas is 45th in the country in number of active primary care providers per 100,000¹

➢ 35 counties without a practicing physician of any kind

➢ 185 of the 254 counties lack a single general psychiatrist²

➢ Growing and aging population
  • 1,200 more people per day³
  • 4.1M enrolled in Medicaid⁴
  • 4.3M uninsured⁵

➢ Downward pressure on State and Federal Medicaid funding

➢ Potential expiration of 1115 Waiver

3. U.S. Census Bureau, 2017
4. Texas HHSC, 2017
5. Texas Medical Association, 2017
QUESTIONS?

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APPENDIX
HPSA Designation

“HPSA” – Health Professional Shortage Area (Primary Care)

➢ Meet one of the following conditions:
  • Population to FTE primary care physician ratio of at least 3,500:1
  • Population to FTE primary care physician ratio of less than 3,500:1 but greater than 3,000:1 and have unusually high needs for primary care services or insufficient capacity of existing primary care providers

➢ Demonstrate that primary medical professionals in contiguous areas are over-utilized, excessively distant or inaccessible to the population under consideration

➢ Facilities must be either Federal and/or State correctional institutions or public and/or non-profit medical facilities

➢ Demonstrate that primary medical care is provided to an area or population designated as a primary care HPSA and there is insufficient capacity to meet the primary care needs of that area or population group
HPSA Designation

“HPSA” – Health Professional Shortage Area (Mental Health)

➢ Meet one of the following conditions:
   • Population to core-mental-health-professional ratio ≥ 6,000:1 and a population to psychiatrist ratio ≥ 20,000:1
   • Population to core-mental-health-professional ratio ≥ 9,000:1
   • Population to psychiatrist ratio ≥ 30,000:1

➢ Demonstrate that mental health professionals in contiguous areas are over-utilized, excessively distant or inaccessible to the population under consideration

➢ Community mental health centers and other public and non-profit facilities must:
   • Provide (or are responsible to provide) mental health services to an area or population designated as having a shortage of mental health professionals; 
     and
   • Have insufficient capacity to meet the psychiatric needs of the area or population
Project ECHO

➢ Project ECHO – University of New Mexico School of Medicine
  • Extension for Community Health Outcomes
  • Links specialists with PCPs in underserved communities
  • Hepatitis-C treatment via telemedicine showed equal efficacy as measured by sustained virologic response

Project ECHO
# Project ECHO

## Treatment Outcomes

<table>
<thead>
<tr>
<th>Outcome</th>
<th>ECHO</th>
<th>UNMH</th>
<th>P-value</th>
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</thead>
<tbody>
<tr>
<td>Non-response</td>
<td>14.4%</td>
<td>11.8%</td>
<td>NS</td>
</tr>
<tr>
<td>SAE</td>
<td>10.4%</td>
<td>20.6%</td>
<td>P&lt;0.01</td>
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<tr>
<td>Minority</td>
<td>69%</td>
<td>49%</td>
<td>P&lt;0.01</td>
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<tr>
<td>SVR Genotype 1/4</td>
<td>48%</td>
<td>50%</td>
<td>NS</td>
</tr>
<tr>
<td>SVR Genotype 2/3</td>
<td>68%</td>
<td>70%</td>
<td>NS</td>
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</tbody>
</table>

- **SAE**=significant adverse event
- **SVR**=sustained viral response