A TO Z
DEVELOPING TELEBEHAVIORAL HEALTH CAPACITY TO SERVE
THE NEEDS OF YOUR PATIENTS

Health Centers
Healthy Start Programs
Ryan White HIV/AIDS Program Grantees and Service Providers
Rural Health Clinics
Session 3
Economics & Partnerships
June 19, 2013
Today’s Speakers

Michael R. Lardiere, LCSW
VP HIT & Strategic Development
National Council for Community Behavioral Healthcare

Phil Hirsch, PhD
Chief Clinical Officer
HealthLinkNow
phirsch@healthlinknow.com

Jonathan Neufeld, Ph.D.
Clinical Director/Principal Investigator
Upper Midwest Telehealth Resource Center
jneufeld@inrhse.net
Goals of the Training

1: Identify for their own organization one or more telebehavioral health service models that are clinically appropriate and a pathway to sustainability;

2: Identify and engage the range of stakeholders necessary to successfully establish telebehavioral health services;

3: Coordinate their telebehavioral health activities with pertinent local, state and federal partners.
• Session I: Overview & Laying the Groundwork  
  May 22, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session I: Office Hours Q+A  
  May 29, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session II: State Regulatory/Reimbursement Topography; Engagement and Outreach  
  June 5, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session II: Office Hours Q+A  
  June 12, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session III: Economics, Partnerships  
  June 19, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session III: Office Hours Q+A  
  June 26, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session IV: Technology and Logistics  
  July 17, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session IV: Office Hours Q+A  
  July 24, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session V: Implementation  
  August 7, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session V: Office Hours Q+A  
  August 14, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session VI: Launch, Refinement, Lessons Learned and Wrap Up  
  August 21, 2013 @ 12:00 PM EST  
  Register [Here](#)  

• Session VI: Office Hours Q+A  
  August 28, 2013 @ 12:00 PM EST  
  Register [Here](#)
The Upper Midwest Telehealth Resource Center is one of 14 Telehealth Resource Centers funded by HRSA

Providing:
- Education
- Technical Assistance
- Individualized Consultation

...to foster the adoption, development, and sustainability of telehealth services.
Outline

I. Billing and Reimbursement Review
II. Viable (or Popular) Business Models
III. Partnerships (and Other Arrangements)
IV. Expanding Reimbursement, New Models
Billing and Reimbursement

I. Medicare

- Originating site must be rural and/or HPSA
- Originating site must be health care provider
- Limited number of CPT codes are covered
- Coding: CPT + “GT” modifier for professional fee
- Coding: Q3014 for facility fee (originating site)
- ***Medicare assumes originating site and provider site are two different legal entities***
Billing and Reimbursement

II. Medicaid
   - Varies by state
   - Many states follow Medicare closely
   - Some cover specific services (OT/PT, Psych, etc.)
   - Coding: usually the same as Medicare
Billing and Reimbursement

III. Commercial
   - Varies by payer
   - ~20 states mandate reimbursement by commercial payers
   - Several payers have national telemedicine policies
Telemedicine Business Models

- TM is not a service, but a delivery mechanism for health care services
  - Most TM services duplicate in-person care
  - Some services are made better or possible with TM
  - Reimbursement usually equal to “in-person” care
  - Regulations are in flux and don’t cover all possible arrangements
Polling Question

Regarding identification of a remote partner to provide Telebehavioral Health services:

- We already have one
- We don’t have one but know where to find one (or more)
- We think it will be difficult, but not impossible, to contract with one
- We think it will be virtually impossible to locate and contract with one
I. Partnering for Remote Specialists

- Traditional “Hub & Spoke” arrangement
- (Rural) clinic schedules and presents patient
- Standard Pro-fee Payment (CPT-based) goes to Specialist (“remote site”)
- Facility fee for Patient Site (“originating site”)
  - Commonly $22-$25 per encounter
  - NOT the same as “facility fee” in Medicare Part A
  - Additional Pro-fee paid to originating site if a physician/APN presenter is medically necessary
I. Partnering for Remote Specialists

- Rural "originating site"
- Specialist "distant site"
- Patient
- Specialist
- TELEMEDICINE

Facility Fee (Part B)
Professional Fee (Part B)
Good Partners

- Academic Medical Centers
- Tertiary Care Hospitals
- Multi-specialty Medical Groups
- Peer Health Care Provider

Key issues that commonly arise:
- Payer mix
- No-shows
Model 1 Example – Union Clinton

Hospital Tele-cardiology Service

- Patient presents in rural ED
- Evaluated by tele-cardiologist
  - **High risk**: triage and transport
  - **Low risk**: imaging/labs, treat, observe, re-evaluate
Model 1 Example – Union Clinton

Tele-cardiology Service (2012)

- 124 cases evaluated (119 kept in CAH)
- $69,000+ in additional revenue at Clinton
  - Reduced overall treatment costs to payers
- High satisfaction for patients, families, and providers
- Direct outreach AND rural benefit

Stephanie Laws:
slaws@uhhg.org  812-238-7479
Alternate Model 1 – Tele-stroke

Tele-stroke Service

- Patient presents at rural ED – identified as possible stroke
- Evaluated by tele-neurologist for t-PA
  - Imaging, labs completed
  - Live 2-way video: patient-neurologist
- Remote neurologist supervises treatment
Alternate Model 1 – Rural Specialists

- Rural RHC or FQHC acts as originating site
  - Scope of services may need to be amended
- Urban medical center provides needed specialists
  - Psychiatry, Other Mental Health
  - Cardiology, Endocrinology, etc.
  - Dentistry
- Medical center bills professional fee
- Rural clinic bills facility fee
Model 1 – Financials & Value

- Revenue Stream
  - More pts treated in rural facility
  - Greater access at rural facility
  - Outreach path to specialty site
  - Profee to specialist; facility fee to clinic

- Cost Avoidance
  - Tx cost savings for patient AND payer
  - More rapid access = reduced overall costs
  - Better access to mental health care can reduce overall medical costs

- Overall value varies for different stakeholders
Model 2 – Specialists Stay Put

- Site-to-site within an organization
- No real “hub” or “spoke”
- Facility fees excluded (?)
- Most internal functions unchanged
- Goals:
  - Reduced travel
  - Increased capacity
  - Increased efficiency
Model 2 Example – Bowen Center

- 5 sites spread across 5 counties
- 70+ miles between furthest sites
- History of specialists driving to sites
- Project began 2009
  - 2 APNs (psychiatric NPs)
  - 2 remote clinics
  - Medication evals/re-evals by TM
Bowen Center Results

Scheduled Time Converted to Billable Time

- NP #1809: Traditional: 80%, Telemedicine: 110%
- NP #1843: Traditional: 60%, Telemedicine: 100%

Traditional Telemedicine

www.integration.samhsa.gov
Bowen Center Results

Days to Initial Appointment

- Traditional Services: 35 days
- APNs: 30 days
- APNs using TM: 15 days
Model 2 – Financials & Value

- Revenue
  - More services, more locations, same staff
  - Greater efficiency
- Cost Avoidance
  - Reduced travel costs (time & money)
  - Fewer no-shows, less cost per no-show
- Value is clear to primary stakeholder
Model 3 – Direct Remote Hiring

- Recruit from anywhere to anywhere
- Retain staff when they move
- Requires new administrative skills, flexibility
- Key consideration: Licensure
  - Care occurs at patient site; provider must be licensed to practice in patient’s state
- This arrangement is “undefined” under Medicare and most state Medicaid
What is meant by “undefined”? 

- The arrangement is compliant with all applicable regulations, but is clearly not what the regulations intend
- 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, equivocal, and contradictory
Two Types of Remote Hiring

“Wholesale”:
- Direct recruitment and hiring
- Two-party agreement (employ/contract)

“Retail”:
- Use third party recruiting/staffing company

Key to Success (in either case):
- Continuity of relationship with the tele-provider (for both staff and patients)
Model 3 Example – Oaklawn

- 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
- Providers see patients from home
  - 2 in Chicago, 1 in Indianapolis
  - 2 are direct hires, 1 is through a third party
Model 3 – Financials & Value

- **Revenue**
  - Existing patients, services, payers
  - Increase capacity in current services or add new services

- **Cost Avoidance**
  - May be cheaper (and better) than other alternatives
Model 3 – Comments

- First mover advantage
  - Services will eventually go to highest bidder
- Relationships are key
  - Flexibility with reasonable limits
- Interest in “remote work” growing in many specialties
Polling Question

We are using, or intending to use Telebehavioral Health to:

- Serve other locations in our agency but keep specialist(s) in one location
- Contract with a specialist outside our agency to provide services within our agency
- Have our employed specialists provide services to agencies outside ours
- Hire specialists and have them telecommute from wherever they are located to our agency.
New & Combo Models

- Payer Contracts
- PCMH
- ACO
- Work Site Clinics
The web site:

http://www.integration.samhsa.gov/operations-administration/cihs-telebehavioral-health

The Listserv:

All Participants will receive an email and a link to join the Listserv

All of the presentations will be archived on the web site
Please utilize the Listserv for communication on issues

Phil Hirsch, PhD  
Chief Clinical Officer  
HealthLinkNow  
206.365.3096  
phirsch@healthlinknow.com  
www.healthlinknow.com

Michael R. Lardiere, LCSW  
Vice President Health Information Technology & Strategic Development  
National Council for Community Behavioral Healthcare  
MikeL@thenationalcouncil.org

Jonathan Neufeld, Ph.D.  
Clinical Director/Principal Investigator  
Upper Midwest Telehealth Resource Center  
jneufeld@inrhse.net  
(574) 606-5038
Attend Session III Economics, Partnerships

When: June 26, 2013 @ 12:00 PM EST
Register Here: https://www2.gotomeeting.com/register/831277722

This and all webinars will be archived and available on the web site:
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