The Colorado Health Foundation™

Pushing Telehealth Out: Where Does Medicaid Fit In?

Q&A with Health First Colorado (formerly Medicaid) Medical Director, Judy Zerzan, MD, MPH



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Where has the Health First Colorado/Medicaid system adopted or encouraged telehealth?

I think one of the hard things in telehealth is talking about what we mean. For us, the video interaction idea in telehealth is called “video medicine.” And then “telehealth,” for us, means remote home health monitoring – scales that send the

person’s weight, things like that. I will say that before now, we felt we were ahead of the curve. I have the first draft of our telehealth policy manual from January of 2009. So we were way early. That being said, I think we’re behind the curve now in terms of how we deliver telemedicine and what that looks like. Probably the biggest barrier we still have in here is that where the member is, looking into a video camera for example, there has to be an originating provider with them in the room. So that doesn’t allow for the “sitting at home on the couch” kind of example.

How has that come to be that bump in the road? Is it your decision? Is it federal mandates?

That is an interesting question. That was how we set it up in the beginning. In 2009 we didn’t have face time and fancy things on our phone; the technology really was located in doctors’ and nurses’ offices. And that has changed, but we haven’t really updated our policy. Some of the places it was so important in Colorado was those rural and frontier places; this was originally designed for someone in a Canon City office to talk to a specialist up here in Denver.

You said we’re behind the curve now. Does that mean you want to make changes?

Yes, we’ve been looking at what other states are doing and how we might modernize. One place we will be looking at early is the places where mental health care providers could be included, since telepsychiatry and telemental health have been two areas that have worked well. Another example of something we haven’t added yet is nursing home care. It would sure be fantastic, when there’s a provider at the nursing home who is asking, “Does this patient need to go to the emergency room? Can I figure out what’s wrong with him or her from the nursing home instead of packing them up and moving them?” So there are areas we are

looking at.

One of the places in telemedicine we've been working on is "e-consult." A test group started this week. It's something that San Francisco and Oklahoma have some great data behind. It allows for a primary care provider to send an email and attach pictures to a specialist, and say, "Can I get your opinion on what's next?" And we pay $10 to the primary care provider and $20 to the specialist. We are just starting with rheumatology to see how the system works. Early data from places that use it shows it really cuts down on the time it takes to see the specialist; 70 to 80 percent of cases are able to be taken care of by the email interaction, meaning that percentage never has to go see the specialist.

This piloting that we're doing, we hope to expand once we see how the system works and how people like it. The specialists and primary docs where it's been done love it because it gets a lot done, often the primary care provider learns something, and they do get paid something for it; you get it down to a couple of minutes because the specialist just knows the information. And the member likes it because they don't have to wait forever to get into a specialist. It's win-win-win.

How close are you to a scenario where Medicaid clients could consult with a provider on their own smartphone, or take a picture of something related to their condition and send it directly to a provider? Is it about the reimbursement rules?

There's a couple of things that need to be in place. The rule would need to be changed, and that's a set process. The medical services board, our rulemaking body, has to approve it after we make a proposal. It also involves how we pay for it. As you probably know, this coming budget year is not looking so good, so anything involving Medicaid expansion would have to be carefully thought out. A

third piece that needs to be in place that's another potential barrier is that there needs to be HIPAA (Health Insurance Portability and Accountability Act) compliant software. Figuring out how to get the existing systems onto your phone could be a data cost, and some of our clients don't have big data plans for that. How do you get the right technology and make sure it works?

The telehealth law passed in the last session only applies to private insurers, not to Medicaid. But still it's worth looking at how we can go about it – do we wade in on our own or learn from private insurers' experience?

You had mentioned needing to know if there are budget implications. Why would there be new costs to the Medicaid budget? If those people are already getting seen for things, why does it matter to Medicaid whether you reimburse for an office visit or for a video visit by their smartphone?

We need to have pieces in place to make sure that visit really happened: What's the documentation? How might we audit something like that? Or how might the federal government come in unasked (laughs) and audit it for us? We'd want to make sure that things were set up in a way we could monitor it, make sure high-quality things were happening, make sure HIPAA-compliant software was being used – all those pieces. That's the tricky part.

One reason it's difficult to assess is that in the private sector that has tried telehealth, a lot of it has been done in a managed care setting, which is different from our setting. States like Maryland that have begun telehealth expected some increases in usage but also expected savings in places like the ER. They decided it was worth it, but those are only educated guesses until you see it in operation.

And it’s harder for us to assess that guess here because the telemedicine benefit we do have is not used that much yet. It’s mostly done by small rural hospitals and for a benefit we have in speech and language assistance. So to open that up has to be carefully considered.

Have you had other long-term telehealth functions in place over the years?

We have had a nurse advice telephone line for years. It’s free, and now those providers do have the ability to prescribe over the phone for certain conditions. A urinary tract infection is a good example; the questions and responses are pretty straightforward. (Patients) can call the nurse advice line; the nurse can get the medication prescribed and ask where they want it sent. So there are absolutely non-face-to-face ways to deliver health care. We contract with Denver Health to provide the staffing for the nurse advice line.

How will you go about making these changes in telehealth? Do you have an internal blue ribbon committee?

We have a process where we start by looking at what other states do, what do other insurers do, is there federal policy on this, what does Medicare do, and putting that all together to see what that looks like. Then we have internal discussions to talk about what are the most important things to change. Then (we have) external stakeholder discussions. Then more questions back and forth. Then we have a final policy and it enters the rule-making process and a budget review and a rate review. It often takes a year for that whole process. We’d also need to get authority from our partners at the Centers for Medicare & Medicaid (Services), and that can take another six months.

How do federal officials feel about telehealth? Are they reluctant? Are they pushing it?

I'd say it's a neutral answer. I'm part of the national Medicaid directors group. It's been a pretty heated topic for the last couple of years – how are people doing it and what does it look like. Places that have learned a lot include Alaska – where if you don't do telehealth, you're traveling on a small plane – and Wyoming. Those are places we can look to and learn from. We're getting a new Medicaid management and billing system up and running October 31 of this year. Our old system was state of the art in the 1970s. It was difficult to add or change things. The new system will be – should be – much more flexible, and we'd be able to do a lot more. That holds some promise for us to be able to change the (telehealth) benefit.

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