Dialing Up Telemedicine in Massachusetts

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PIONEER INSTITUTE
PUBLIC POLICY RESEARCH

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Introduction

Technology occasionally upends entire industries, as seen with the rise of ride-sharing apps in just a few short years. Uber and Lyft leverage convenience and efficiency advantages over traditional taxis to create a better consumer experience. This theme of improving systems by using technology to engage consumers is also a significant factor in the rise of online shopping and personal banking. One industry that has remained relatively insulated from these consumer-facing conveniences is healthcare.

When videoconferencing technology became ubiquitous in business in the 1990s, Medicare was fairly quick to apply these principles to healthcare by approving reimbursement for limited forms of telemedicine. Even as evidence of the efficacy of telemedicine has grown, there has been little change in national policy. Only one form of telemedicine is allowed under Medicare, and most state-based policies are modeled after this first attempt to integrate telemedicine into the larger healthcare system.

Commercial insurers have taken the lead on exploring telemedicine's opportunities, and some states have been more aggressive than others when it comes to adopting it. Massachusetts is one of only two states that do not mandate telemedicine coverage for Medicaid recipients. This is inconsistent with the Commonwealth's reputation as a biotechnology and healthcare innovator. As Massachusetts plays catch up, there are still outstanding disagreements in the industry over telemedicine best practices and the appropriate scope of coverage.

What is Telemedicine?

Whether connecting a rural resident with a specialist or allowing a remote radiologist to read an x-ray, telemedicine can be implemented and made useful in virtually any facet of healthcare. Its uses can generally be classified into three main categories:

1. Live-interactive appointments
2. Store-and-forward of medical information
3. Remote patient monitoring

Most state-approved telemedicine programs focus on live-interactive engagement between a doctor and patient. This typically takes the form of a videoconference, since audio-only connections are either not covered or explicitly forbidden in most states. Live-interactive appointments, or synchronous communication, closely simulate in-person meetings, and can allow rural patients to more conveniently access primary and specialty care. Live-interactive approaches are also the most studied form of telemedicine and have been shown to improve patient satisfaction and outcomes,[1] as well as save time and money for both physician and patient.[2]

Store-and-forward approaches allow patients, or other physicians, to communicate asynchronously with a physician through email or a web application such as a patient portal. They are commonly employed in fields such as dermatology, radiology, and pathology, where tests are often interpreted after the conclusion of an appointment. For these services, immediate responses are unnecessary. Store-and-forward systems can also enable rural patients to seek specialist expertise from flagship medical centers without traveling long distances.

Remote patient monitoring is most commonly used for post-surgical patients and individuals with chronic and/or multiple medical conditions, allowing them to remain at home while a medical device, such as a blood sugar or heart rate monitor, relays information to their doctor. Remote patient monitoring has been used to aid treatment of a diverse range of chronic conditions including diabetes, heart and renal failure, HIV/AIDS, and cancer. Patients who can return home more quickly are shown to have higher satisfaction and improved outcomes.[3]

As handheld device processing power and ubiquity increases, the potential applications for telemedicine broaden. In regulating this growing industry, states need to be careful to invite innovation and prevent regulations that create unnecessary limitations.

Does Telemedicine Work?

With varying levels of qualification, prominent medical groups such as the American Hospital Association,[4] American Medical Association,[5] the American College of Physicians,[6] and the Massachusetts Medical Society[7] have all endorsed the use of telemedicine to reduce costs and increase efficiency and patient satisfaction. The data consistently backs up these claims.

In a review of thousands of independent studies, the American Telemedicine Association found potential for savings across the industry. Nationally, utilizing telemedicine to connect rural emergency departments instead of transferring patients is projected to save $537 million annually, while correctional facilities stand to save $270 million, and nursing homes could see savings of $806 million. The cost of managing chronic conditions was cut by about 10 percent, while hospital-at-home programs saw savings of 19 percent along with higher satisfaction rates and briefer treatment periods.[8]

Reviews of quality outcomes show that while telephone conversations are associated with slightly worse outcomes, live-interactive videoconferencing produces results that are equal to or better than in-person visits. Telemedicine also yields consistently higher patient satisfaction rates since it allows them

to remain amidst the comforts of home. This allows for a much more efficient use of both the patient's and doctor's time.[9]

There are virtually no groups categorically opposed to using telemedicine, only those with concerns about its efficacy in complex or sensitive cases. Indeed, telemedicine can be used to uniquely target some of healthcare's most pressing issues. By connecting rural patients with urban doctors, it can help fill geographic gaps in primary and specialty care; home monitoring and check-ups can help those struggling with mental health problems or addiction; as health plans experiment more with alternative payment methodologies in lieu of traditional fee-for-service arrangements, telemedicine can more easily enable doctors to care for patients holistically; and patients with chronic conditions that account for upwards of three-quarters of healthcare spending could spend less time at the hospital, pay less for care, and adhere more closely to their doctor's orders.[10, 11]

Given the near-universal support telemedicine receives, the next question is how states have chosen to regulate or limit this burgeoning healthcare delivery model.

National Telemedicine Policy

Medicare

Medicare largely led the early adoption of telemedicine, and many states have since crafted their systems around the Medicare model's core features. Medicare first approved reimbursement for some services provided through telemedicine in 1997, and allowable instances were expanded in 2001. Under the Medicare model, only live-interactive meetings can be reimbursed, the patient must be in a rural Health Professional Shortage Area (HPSA) and at a recognized health center (the "originating site") where the remote physician has admitting privileges, and insurance companies must reimburse providers at the same rate as an in-person visit is remunerated.[12] The originating site requirement and provision limiting coverage to live-interactive appointments are based in statute and would require legislative action to alter.[13]

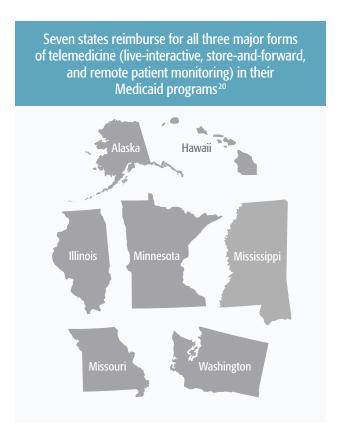The list of services covered under Medicare is subject to annual

revisions, but generally grows each year. Currently, a wide range of services are reimbursed, from a normal primary care visit, to mental health services, to obesity behavior counseling and nutrition therapy.[15] Medicare has begun to loosen some of its restrictions, allowing store-and-forward services to be reimbursed in Hawaii and Alaska in 2014.[16] In 2015, Medicare also expanded telemedicine reimbursement to all patients with two or more chronic conditions, eliminating its originating site requirement for a specific population for the first time.[17]

Medicaid

Medicare's early, albeit limited, adoption of telemedicine services has formed the basis for most states' Medicaid provisions, but many have chosen to take telemedicine further. States have wide authority to design their Medicaid program and its associated benefits, and while Massachusetts does not forbid telemedicine reimbursement, it is not mandated either. This murky situation results in uneasy providers and payers, and a lack of will to create telemedicine programs.

As of August 2016, live-interactive encounters are covered in 48 states, while 12 states reimburse for some forms of store-and-forward (beyond simple radiological coordination), and 19 reimburse for remote patient monitoring.[18] Medicaid programs also do not typically include onerous originating site requirements, with 25 states allowing for the patient to remain at home.[19]

Allowable originating sites	
Physician or practitioner's office	Hospital
Rural health clinic	Skilled nursing facility
Federal qualified health center	Community mental health center[14]

Seven states reimburse for all three major forms of telemedicine (live-interactive, store-and-forward, and remote patient monitoring) in their Medicaid programs[20]

Each state has slightly different allowable services, although many closely mirror Medicare's list. Massachusetts is one of two states (Rhode Island is the other) that do not categorically reimburse any services for Medicaid patients.[21] However, nearly half of MassHealth beneficiaries are enrolled in managed care plans,[22] which may include telemedicine services at the administrator's discretion.[23]

National Telemedicine Trends

In a period of historically partisan politics, a bipartisan bill has been filed in the Senate that would revamp the Medicare standards which currently cover "limited telehealth services, setting a poor industry standard, discouraging innovation, and restricting access to specialized services," according to the sponsors.[24] But while national momentum is growing behind telemedicine, further adoption is still largely being handled at the state level.

More states are beginning to test the efficacy of alternative telemedicine delivery methods, with trial periods for store-and-forward and remote patient monitoring currently ongoing in multiple states.[25] Some others are pioneering telemedicine to meet their own unique needs. California, which mandated commercial telemedicine coverage, allowed store-and-forward, and did away with originating site restrictions in 2011 to help its rural residents.[26] While many states have telemedicine parity laws, requiring private payers to cover live-interactive video chats, most states are lagging behind the commercial market's level of adoption and innovation.

One of the biggest areas of contention in the current telemedicine debate surrounds reimbursement parity. Twenty-three states require full reimbursement parity—payments at the same level as an in-person visit—in their commercial markets, while nine others have some sort of parity law on the books.[27] Reimbursement parity ensures that providers and payers are willing to explore telemedicine offerings, since it would likely increase profit margins. At the same time, one of telemedicine's most attractive selling points is its ability to lower overall healthcare costs, an effect that full reimbursement parity dampens.[28]

Despite governments' reluctance to expand telemedicine, private insurers and providers are seeing the potential for massive cost savings — an average of $126 per acute care visit.[29] National telemedicine companies have also begun to pop-up, making it easier for large insurers to include these services in their offerings. Most states have mandated commercial reimbursement parity; those that do not set some sort of standard create an environment less conducive to telemedicine taking root.

Commenting on the aforementioned bipartisan legislation, the CEO of a large telemedicine provider noted that "while Americans under 65 have almost ubiquitous access to the world of online healthcare [through private insurers], those of us who are frail, the homebound, those who need it frequently and are challenged the most to access it — our 65-plus elderly — are denied access to it. A mind boggling social injustice that is excused by red-tape and antiquated pre-iPhone regulations."[30]

Massachusetts Telemedicine Policy

Massachusetts' seeming hesitancy to adopt telemedicine is inconsistent with the presence of a strong biotechnology industry and innovative academic medical centers. Although there are currently numerous bills before the state legislature, it's unclear if this topic will receive significant attention as all eyes turn to healthcare spending's impact on a precariously balanced state budget, consistently troublesome provider price variations, and a debate over the fundamentals of healthcare in Washington.

Massachusetts is one of only two states that does not mandate telemedicine coverage for Medicaid recipients, and do not have a private payer reimbursement parity law. Currently, the state Health Policy Commission (HPC) is running telemedicine pilot programs aimed specifically at behavioral health needs,[31] while the legislature considers bills that would mandate telemedicine coverage in the Group Insurance Commission (the state's public employee healthcare administrator), Medicaid, and other forms of insurance. These bills vary slightly in what forms of telemedicine are allowed – some include store-and-forward or have location-based restrictions – but all include reimbursement parity provisions and don't require identifying barriers to an in-person appointment.[32, 33]

Following Medicare's lead, Chapter 224 of the Acts of 2012 allows private insurers the option of reimbursing telemedicine services. Only live-interactive services are covered, deductible and coinsurance charges cannot exceed that of in-person visits, and all allowable in-person services must also be covered through telemedicine. Notably, there are no location restrictions placed on the patient. Currently, at least Cigna, Harvard Pilgrim, and United Healthcare operate telemedicine programs in Massachusetts, and some providers, such as Partner's HealthCare, have created their own web tools or apps to be included in some health plans.

Harvard Pilgrim, for example, allows virtually all their members to utilize telemedicine for any appropriate covered service. In fact, they have a Doctor On Demand program that allows members to quickly contact a physician, whom they may have never seen before, for simple questions or diagnoses.[34]

CONCLUSION

Telemedicine is here to stay, and its capabilities and integration with the healthcare system will continue to increase. As the Commonwealth struggles to contain healthcare costs and meet its own cost growth limits, this field offers an opportunity to significantly reduce costs while increasing patient satisfaction. Massachusetts has not taken the lead on telemedicine. As it plays catch up, it must be careful not to place needless restrictions on such promising practices.

1 **Continue studying telemedicine's various applications and embrace its uses in areas where it is proven successful.**

While there is already a large body of research dealing with telemedicine, most states restrict its use to specific situations and technologies. While there has been some legislative action pushing pilot programs, Massachusetts should make sure to leave the door open for new advances to ensure that telemedicine provides the greatest possible benefit. While the jury is out on live-interactive appointments, there is still work to be done in proving the efficacy of some store-and-forward and remote patient monitoring systems. That said, these approaches are increasingly seen as necessary elements of a well-rounded healthcare system.

2 **Do not restrict the originating site.**

Originating site requirements when a patient has a preexisting relationship with the physician are unnecessary and run contrary to the convenience telemedicine is supposed to provide. Patients with multiple chronic conditions or who have recently had surgery will find that staying at home is preferable to traveling to a healthcare facility. Whenever diagnostic integrity won't be threatened, new approaches should be pursued.

3 **Consider allowing reimbursement at less than the in-person charge in some cases.**

The promise of telemedicine lies in its convenience and cost savings. Requiring full reimbursement for all services delivered remotely undercuts one of these core benefits. While rates must begin at close to full reimbursement to entice providers and insurers to participate, over time telemedicine will become ingrained in healthcare and the price should migrate closer in line with the actual cost of providing the service. This is especially true with quick phone calls or supplementary interactions that should not constitute a formal appointment.

4 **Lead the charge to adopt telemedicine through the Group Insurance Commission (GIC), Medicaid, and other state-run health programs.**

The GIC, the state's public employee healthcare administrator, has consistently pursued progressive approaches to controlling healthcare costs, most recently with the Vitals SmartShopper program, which offers cash incentives to consumers who value shop for non-emergent care. The GIC and other publicly run healthcare programs should be given autonomy and encouraged to continue seeking new and innovative approaches to cost containment, especially with regards to telemedicine. Such action on the public side will help move the commercial market towards similar practices.

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About Pioneer

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