The Business Aspects of Telemedicine and e-Health

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Program Topics

1. Revenue Streams
   • Contracts and Grants
   • Parent Org/Philanthropy
   • Patient Services Reimbursement
   • Service or User Fees

2. Expense Considerations

3. Regulatory Issues
Revenue Streams

- Contracts and Grants
- Parent Organization Support and Philanthropy
- Billing and Collection Activities
- Service or User Fees

Contracts & Grant Funding

- There are many government contract and grant funding opportunities (see Resources page)

- Usually the candidate needs to submit a sustainability plan to obtain funding

- This ensures the project will continue at the end of the contract or grant period
Parent Organization and Philanthropy

- Some organizations or donors will fund the initiation of a new telemedicine program
  - Must support mission

- The support will probably be time-limited and a sustainability plan will need be developed

Patient Services Reimbursement

- Clinical needs identified
  - Which technology?
  - Consulting versus ongoing treatment
  - Referring provider & patient expectations
  - Payment/Reimbursement mechanism
    - Block time
    - Fee for Service
    - Protocol for uninsured (?) or denied/non-covered services

- Paying for the network???
  - Is this still an issue?
Patient Services Reimbursement

- Government Payers – Regulatory mandates apply
  - Medicare – Limited services, Real Time only, rural areas
    - For 2017, New Place Of Service (Telehealth)
    - For 2017 8 new codes in ESRD, Advance care planning, Critical Care Consults
    - For 2017 still no on Observation, ED, Psychological Tests, PT/OT, Speech Path
  - Medicaid – State by state, Arizona covers almost all services
  - Tri-Care – Follows Medicare
  - Veterans Administration – Has its own system and uses telemedicine
- Private Insurance – variable and inconsistent
  - Requesting CBO to give M-Care “a fair shake” and look at their data/VA/M-Caid
- Outdated CPT/HCPCS formula does not align well with TM/TH
- Direct to Consumer/Self Pay

PPACA

- State exchanges are supposed to cover Telehealth/Telemedicine
- Telemedicine is part of the “alternative payment methods” provision effec 2017
- Telemedicine is part of federal health IT initiatives and gaining bi-partisan support in congress and throughout industry

Source: ATA general updates webcast 1/28/14
Patient Services Reimbursement

- Patient billing and collections are generally not a good primary mechanism to pay for a telemedicine program ... **Unless**

- It is a closed or capitated clinical environment where significant cost savings can be realized ... **OR**

- Viewed as “Loss Leader”

Service or User Fees

- Allows the program to distribute fixed expenses
- For every minute the equipment and telecom lines sit idle, the program experiences lost opportunity
- Other uses for network:
  - Education
  - Administrative meetings
  - Business activities, email
  - Clinical Conferences
  - Support groups
ATP Membership Model
(example of a telemedicine business model)

- Structured after an Application Service Provider (ASP) model

- ATP has initiated several partnerships with independent providers and agencies across the state

- Shared communications infrastructure results in economies of scale

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Business Model

Application Service Provider Enterprise

Client Layer
Professional Services Layer
Operational Services Layer
Infrastructure Services Layer
Vendor Services Layer

Membership based
ATP Benefits

• Statewide infrastructure for the Department of Corrections telemedicine program

• Development of major technology transfer program

• Establishment of e-healthcare

• Improved access to specialty medical care for rural population

Other ATP Membership Benefits

• New healthcare partnerships in state

• Delivery of continuing education to rural health care providers and patient support groups

• University acting as a statewide resource

• Economic development
Expense Considerations

• Fixed and Variable Expenses
  • Personnel
  • Equipment and operations
  • Technology
  • Overhead

• Some expenses could fall into either category AND need to be considered for both the referring and receiving sites
  • As TM continues to become more mobile, expenses will be reduced
## Expense Considerations

### Personnel – all sites

<table>
<thead>
<tr>
<th></th>
<th>Fixed</th>
<th>Variable</th>
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<tbody>
<tr>
<td>Medical director</td>
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<td>(NP)*</td>
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<tr>
<td>Site coordinator</td>
<td>X</td>
<td>(NP)*</td>
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<tr>
<td>Other clinical</td>
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<td>X</td>
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<tr>
<td>Technical</td>
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<td>X</td>
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<tr>
<td>Administrative</td>
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*Not Preferred

### Equipment and operations – all sites

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<tr>
<td>Network equipment*</td>
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<tr>
<td>Installation costs*</td>
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<td></td>
</tr>
<tr>
<td>User end equipment*</td>
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<td></td>
</tr>
<tr>
<td>Transmission costs</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Supplies (clin,tech,ops)</td>
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<td>X</td>
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<tr>
<td>Travel and training</td>
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* Non-recurring expense
Expense Considerations

Technical and Maintenance – all sites

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<td>Help Desk</td>
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<td>X</td>
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<tr>
<td>Equip refresh fund</td>
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<td>(NP)</td>
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<tr>
<td>Other??</td>
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Expense Considerations

Overhead

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<th>Fixed</th>
<th>Variable</th>
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<td>Medical records</td>
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<td>Billing &amp; Collection</td>
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<td>X</td>
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<td>Human Resources</td>
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<td>X</td>
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<td>Contracting</td>
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<td>Legal and Compliance</td>
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<td>Malpractice</td>
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<tr>
<td>Central Administration</td>
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<td></td>
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<tr>
<td>Other ??</td>
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</table>
Other Considerations

• Reduced transportation costs
• Improved access to clinical/specialty services
• Convenience for customers and providers
• Referring physicians learn from specialists
• Network availability for other services
  • (As mentioned: education, administration, clin conferences, support groups)
• Value added list
• Expanded market base

Regulatory
Hospital Privileging

• “Medicare requirements remove barriers to the use of telemedicine for medically necessary interventions and uphold the Joint Commission’s existing practice of allowing an originating site (where the patient is located) to use the credentialing and privileging information from a distant site when making final privileging decisions for telemedicine practitioners.”
  http://www.jointcommission.org/assets/1/6/Revisions_telemedicine_standards.pdf

Interstate Licensure

• For the most part, telephysicians fall under the same out of state licensure requirements as in person (patchwork of rules)
  • VA and IHS
  • 25 states (incl AZ) have already adopted the Federation of State Medical Boards (FSMB)’s Interstate Medical Licensure Compact but are in fight with FBI over background checks
  • Some states already have limited telephysician licenses or exempt some services (telerad consults)

• Nurses already have licensure compact /25 states have signed eNLC)
  • Need 26 to activate Enhanced Nurse Lic Compact (includes T-health)
Interstate Licensure

- Interstate Physical Therapy License (FSBPT)
  - 13 states signed on and is live

- Psychology Interjurisdictional Compact (PsyPACT)
  - Nevada, Arizona and New Mexico have signed on, need 7 states to go live
  - Texas, Illinois and Rhode Island have pending legislation
  - Wisconsin, Missouri and Ohio are considering

Malpractice coverage
- No reported problems in AZ
- ATA website for telemedicine carrier info (see resources slide)

Reimbursement coverage
- Already discussed

House committee on Energy & Commerce working to eliminate TM barriers for M-Care patients (ATA, 2015)
Other Regulatory Issues

- HIPAA
  - Compliance at all sites
  - Some agencies do not require HIPAA (DOC) yet standards must be maintained for all network members
  - HIPAA issues with mobile applications
  - Future: HIPAA on steroids???

Resources

- Joint Commission Information Hospital Privileging:

- Telemedicine Reimbursement:
  - Private pay info: http://www.telmedinsurance.com/

- Telemedicine Insurance Information: http://www.hubinternational.com/telemedicine/

- Grants:
  - Gov: http://www.grants.gov/applicants/find_grant_opportunities.jsp
  - Priv: https://proposalcentral.altum.com/ (you must create a login)


- Parity Legislation Information:
Questions?

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