Use Technology to Improve Access to Primary Care:

Advancing Primary Care Innovation in Medicaid Managed Care

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Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit

This module is part of *Advancing Primary Care Innovation in Medicaid Managed Care: A State Toolkit*, which was created to help states leverage their managed care contracts and request for proposals to advance innovation in primary care.

The two-part toolkit outlines strategies to support states in: (1) defining primary care priorities and advancing core functions; and (2) achieving primary care innovation goals through managed care contractual levers.

To view the full toolkit, visit **www.chcs.org/primary-care-innovation**.

Technology can enhance the capacity of primary care providers (PCPs) to address a wider range of needs, such as behavioral health issues. "Telehealth" refers broadly to electronic and telecommunication technologies and services that support remote care delivery. It can be divided into two broad categories: provider-to-provider platforms and direct-to-consumer platforms. Reimbursement and regulation of telehealth in Medicaid vary from state to state. Almost all states (49 and D.C.) reimburse for live video services, but fewer reimburse for remote patient monitoring.[1]

Telementoring programs also have the potential to enhance primary care capacity and increase access to services. For example, Project ECHO is a provider-to-provider model that connects expert specialist teams to primary care clinicians via weekly videoconferences to help them treat patients with complex health needs, especially in rural and underserved communities.[2] Through telementoring and guided practice, participating providers develop the competencies needed to effectively manage their complex patients independently and in their communities. Unlike teleconsultations, the goal of Project ECHO is to expand the capacity of PCPs to independently manage their patients with complex health care needs. A 2011 study found that patients receiving care from primary care providers who participated in ECHO received care that was either comparable or, in some circumstances, better than those who received care from specialists at the University of New Mexico Health Sciences Center.[3]

Similarly, telepsychiatry peer-to-peer models create opportunities for consultation between PCPs and psychiatric specialist providers to enhance primary care capacity. This type of model may be aimed at particular populations, such as children and new mothers as in the **Massachusetts** Child Psychiatry Access Program, or children prescribed psychotropic medications in the **Pennsylvania** Telephonic Psychiatric Consultation Service Program (TiPS). In one study, specialty-related eConsults at a Community Health Center in **Connecticut** resulted in costs of $82 per patient per month less than for face-to-face visits for a Medicaid population.[4]

This module outlines design considerations, provides examples of state approaches, and sample procurement and contract language for states seeking to support telehealth services within Medicaid managed care programs.

USE TECHNOLOGY TO IMPROVE ACCESS:
Design Considerations Summary

Explore flexible versus prescriptive approaches.

✔ Will the state encourage telehealth activities generally, or require buy-in to a particular centralized model?

Define the roles/responsibilities of the state, primary care teams, and MCOs.

✔ How will the state identify and address barriers to the uptake of telehealth or telemedicine services in their Medicaid managed care contract?

Determine how to measure, monitor, and reward progress.

✔ Will the state include measures relating to telemedicine or telehealth?

Leverage payment reform to drive innovation.

✔ How can VBP arrangements include telemedicine or telehealth services?

Determine the need for additional investments.

✔ How can the state and MCOs invest in common telehealth infrastructure and programs to support PCPs?

Design Considerations

✔ *Will the state encourage telehealth activities generally, or require buy-in to a particular centralized model?*

Some states may choose to promote use of technology among MCOs and providers more generally, or to encourage or require a specific approach to meet particular needs they have identified in their state. For example, physical health MCOs in **Pennsylvania** must work with all other physical health and behavioral health MCOs in a health care region to collaboratively choose one psychiatric consultation team. This requirement sustains earlier efforts by MCOs to develop a centralized TiPS program. While this centralized approach allows for less variation at the community-level, the broad availability of the program, no matter the specific affiliation with a plan, may increase uptake of the service.

✔ *How will the state identify and address barriers to the uptake of telehealth or telemedicine services?*

States may consider identifying and addressing barriers to telehealth uptake. Common barriers include access to technology and broadband, licensure, privacy concerns, and state law and reimbursement policies.[8] In Medicaid reimbursement, a common restriction is on the "originating site," or where a patient is located. Many policies exclude a patient's home as an originating site, but 13 states explicitly allow and reimburse service to a patient's home.[9] However, less restrictive policies alone may not incentivize the uptake of telehealth services.[10]

Managed Care Procurement

RFP

Following is sample state managed care request for proposals and request for information language related to telehealth:

Hawaii.[5] "How can […] health plans support initiatives like Project ECHO and expand the reach to all provider groups? What barriers do you see in providing this support and what solutions would help overcome these barriers?"

North Carolina.[6] "[Response shall include […]]

Experience with innovative telemedicine modalities and pilot programs in other states/markets, and the proposed telemedicine approach to encourage use of telemedicine, including types of programs, and targeted providers, geographies (including rural), services, and members."

Virginia.[7] "Offerors shall consider the following when establishing and maintaining its networks: […]

The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

Offerors, in response to this RFP, also shall identify any deficiencies in its provider network that meets access to timely care for services and provide the plans to overcome such deficiencies."

States may also assess how MCO prior authorization or utilization management processes have affected access to telemedicine services. The state may clarify expectations surrounding reimbursement for telemedicine services in its managed care contracts and note both appropriate and inappropriate limitations: for example, whether the plan may require providers to use certain platforms or require an in-person consultation for certain services. The state may also consider mechanisms by which PCPs can access information on telemedicine services, such as prescribed medications and exam findings.

✓ *How can the state and MCOs invest in common telehealth infrastructure and programs to support PCPs?*

States may fund telehealth programs in a variety of ways. Telemedicine services are often considered when developing capitation rates for Medicaid MCOs, and can be bundled into VBP contracts.

Telementoring and peer-to-peer consultation activities may not be in themselves a billable service, which sometimes requires more creative funding structures. In **New Mexico**, for example, the state embeds specific funding for its Project ECHO initiative in the MCO capitation rate, and in turn requires MCOs to pay for its "fair share of administrative costs" for Project ECHO. MCOs may also voluntarily fund common telehealth infrastructure. For example, in 2017, the **Oregon** Rural Practice-based Research Network developed a multi-payer infrastructure, called the Oregon ECHO Network, to support a coordinated network of ECHO hubs around the state and provide programming and support services. Eight of the 16 CCOs, covering 75 percent of the Medicaid population, subscribe to this service.[13]

Managed Care Contract Excerpts

Following is sample state managed care contract language related to telehealth services:

New Mexico.[11] "The contractor shall participate in Project ECHO, in accordance with State prescribed requirements and standards including, but not limited to, paying its fair share of administrative costs as negotiated between the CONTRACTOR and Project ECHO and approved by HSD to support Project ECHO and shall"

"Work collaboratively with the University of New Mexico, HSD, and Providers on Project ECHO;"

"Identify high needs, high cost Members who may benefit from their providers participating in Project ECHO;"

"Identify PCPs who serve high needs, high cost Members to participate in Project ECHO;" …

"Reimburse Primary Care clinics for participating in the Project ECHO model;"

"Provider Claims data to support evaluation of Project ECHO; …"

"Track quality of care and outcome measures related to Project ECHO…"

Virginia.[12] "The Contractor shall provide coverage for telemedicine services as medically necessary, and within at least equal amount, duration, and scope as is available through the Medicaid fee-for-service program. Telemedicine is defined as the real time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment services. Telemedicine may also include 'store and forward' technology, where digital information (such as an X-ray) is forwarded to a professional for interpretation and diagnosis."

State Approaches

Flexible	Prescriptive
Virginia recognizes a wide variety of providers as "remote" providers for telemedicine and allows MCOs the ability to cover specialist consultative services like telepsychiatry as requested by a member's PCP.[14]	**New Mexico** requires its MCOs to participate in Project ECHO by contracting with the New Mexico Health Sciences Center, which operates Project ECHO programs in the state, and reimbursing primary care clinics for Project ECHO. The state embeds funding for Project ECHO into the MCO capitation rate and expects MCOs to pay its fair share of administrative costs for the program. The contract also requires MCOs to reimburse PCPs for participating in the program.
Arizona directs its MCOs to engage members through technology, including web-based applications and mobile device technologies, and to identify populations that can benefit from web- and mobile-based technology used to assist members with self-management of health care needs.[15]	**Pennsylvania's** Telephonic Psychiatric Consultation Service Program increases the availability of peer-to-peer child psychiatry consultation teams to PCPs and other prescribers of psychotropic medications for children. The state's MCOs are required to contract with a telephonic Psychiatric Consultation Team that provides real-time telephonic consultative services to PCPs and prescribers.[16] The team must include a child psychiatrist, behavioral health therapist, and a care coordinator.

Measurement and Payment

States may choose to define targets relating to the uptake of telehealth services. For example, **New Mexico** includes a telemedicine target as one of several "delivery system improvement performance targets." The MCO must increase the number of unique members served through telemedicine visits with physical health and behavioral health specialists by 20 percent in rural, frontier, and underserved urban areas, as compared to the previous year. Twenty out of 100 points is allocated to a telemedicine target. The state imposes performance penalties of 1.5 percent of the capitation rate if the performance targets are not met.[17]

Moving Forward

As the pace of telehealth accelerates, states may consider not only the ways that telehealth may increase access to care, but also the ways in which it may exacerbate disparities. For example, Medicaid recipients are less likely to use telehealth tools, such as patient portals and live video communication. [18,19] In order for telehealth to realize its potential for Medicaid populations, states may look to its MCOs and providers to design creative engagement strategies for Medicaid populations.

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About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It works with state and federal agencies, health plans, providers, and community-based organizations to develop innovative programs that better serve beneficiaries of publicly financed care, especially those with complex, high-cost needs. To learn more, visit **www.chcs.org**.

ENDNOTES

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