Washington State Health Care Authority

REPORT TO THE LEGISLATURE

Tele-Psychiatry Consultation Benefit

Substitute Senate Bill 5883, Section 213(1)(ss), Chapter 1, Laws of 2017, 3rd Special Session PV

October 1, 2017

Tele-Psychiatry Consultation Benefit

Acknowledgments

This report is the result of collaboration between the Health Care Authority and the Behavioral Health Administration, Division of Behavioral Health Resources, at the Washington State Department of Social and Health Services. HCA appreciates the contributions of its partner in providing subject matter expertise.

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Background

Substitute Senate Bill 5883, Section 213(1)(ss), Chapter 1, Laws of 2017, 3rd Special Session, states, *"The authority shall evaluate adding a tele-psychiatry consultation benefit for medicaid covered individuals. The authority shall submit a report with the cost associated with adding such a benefit to the governor and appropriate committees of the legislature by October 1, 2017."*

The budget proviso indicates that tele-psychiatry is not a covered benefit. However, tele-psychiatry is currently covered under Medicaid as a part of behavioral health services through tele-health systems, as required by policy. For the purposes of this report, we will assume the Legislature is requesting data on tele-psychiatry and tele-behavioral health for Medicaid covered individuals.

The Health Resources and Services Administration (HRSA) defines tele-health as "the use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration".[1] This report will refer to tele-medicine services for behavioral health care between a patient and provider. For this report, we will assume the legislature is interested in the full scope of tele-behavioral health, including but not limited to tele-psychiatry. The more strict definition of tele-psychiatry, limited to a psychiatrist/patient interaction, does not fully capture the breath of behavioral services being delivered through tele-health. Tele-behavioral health is more inclusive of all professions that provide services via tele-health technologies. An example of tele-behavioral health is a counselor who provides clients with substance abuse counseling via video-conferencing and is not practicing psychiatry or clinical medicine. In addition, there are other modalities of tele-health not addressed in this report: store-and-forward[2]; mobile health; remote monitoring of client health; and provider-to-provider consultation, such as the Partnership Access Line[3] (PAL). In accordance with RCW 74.09.325(9), the Health Care Authority will report to the Legislature in 2018 more broadly on tele-health, its impact on access to care for underserved communities, and the associated costs to the state.

The tele-psychiatry and tele-behavioral health benefits are within the larger tele-health coverage and are a Medicaid paid service for fee-for-service (FFS), managed care organizations[4] (MCO), and Behavioral Health Organizations (BHOs, previously regional support networks, RSNs). Medicaid FFS and MCOs cover tele-health (including tele-behavioral health) when it substitutes an in-person encounter—and only for services specifically listed in this telemedicine section. The Medicaid fee-for-service physicians' guide defines tele-health as when "a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based

[1] Health Resources and Services Administration Federal Office of Rural Health Policy. 2017. Available from: http://www.hrsa.gov/ruralhealth/tele-health/
[2] Transmission of a patient's medical information from the office of a health-care professional to a provider for consultation at a different site without the patient being present.
[3] University of Washington Psychiatry Consultation and Tele-psychiatry's PAL program
[4] Data from fully integrated managed care (FIMC) is included within the MCO data set.

applications)" to provide health care services. Services can be performed from clinic to another remote clinic or from a clinic directly to the client's home.

Generally, Medicaid managed care organizations mirror the benefit coverage of fee-for-service. By federal law (Social Security Laws, Sec. 1903), Medicaid managed care organizations are required to have health care benefits no more restrictive than the coverage parameters adopted by Medicaid fee-for-service.

According to the Service Encounter Reporting Instructions (SERI) guide, telemedicine services have been a paid benefit within BHOs (and previously regional service networks) since January 2009. However, the tele-health benefit was limited to a subset of services and provider types, including psychiatrists and licensed social workers. The October 2017 revisions to the SERI guide allows behavioral health agencies to provide mental health and substance use disorder treatment via telemedicine for the majority of services covered by the BHO system. Limitations on provider types were removed. These updates aligned the SERI to recent changes in state law addressing tele-health.

Purported benefits of tele-health include improved health care services through access to specialty care providers, such as psychiatrists; removal of barriers for clients who have mobility or transportation challenges; and cost effectiveness.[5] Approaches such as tele-health may increase access in rural areas and under-served areas or help address experienced or perceived stigma due to false perceptions or judgements about mental health or substance use disorders. Cultural or demographic factors may also influence an individual's decision to access behavioral health care. Certain populations may have strongly held negative connotations or beliefs related to behavioral health issues. Though some research has indicated that navigating cultural differences between patient and provider may be more challenging during tele-health encounters[6], it is a valuable tool when providers are trained and able to deliver culturally and linguistically appropriate services.[7]

Utilization and Fiscal Impact

Data Methods

To determine the utilization and fiscal impact of tele-behavioral health as a Medicaid benefit, we retrieved calendar year (CY) 2015-2016 claims and encounters from the ProviderOne system for clients who receive services through either fee-for-service, MCOs, or BHO/RSNs.

[5] Increasing Access to Behavioral Health Care Through Technology. 2012. U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration.
[6] Using e-Health to Enable Culturally Appropriate Mental Healthcare in Rural Areas. 2008. Peter Yellowlees, et al., Telemed J E Health.
[7] Telecounseling for the Linguistically Isolated. 2014. Yuri Jang, et al., Gerontologist.

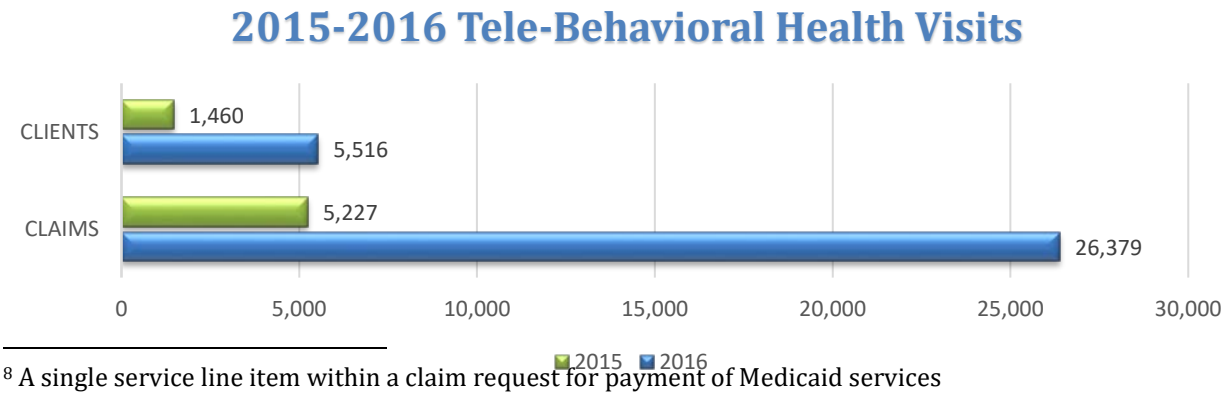
The tele-behavioral health data is drawn from Medicaid claims and encounters for tele-health services provided by a credentialed provider and focused on behavioral health care (treatment for mental health and/or substance use disorders). Behavioral health care visits were identified by a list of 2,498 International Classification of Diseases (ICD-9) and (ICD-10) diagnosis codes, specific to mental health and substance use disorder-related diagnoses.

Service Utilization and Costs

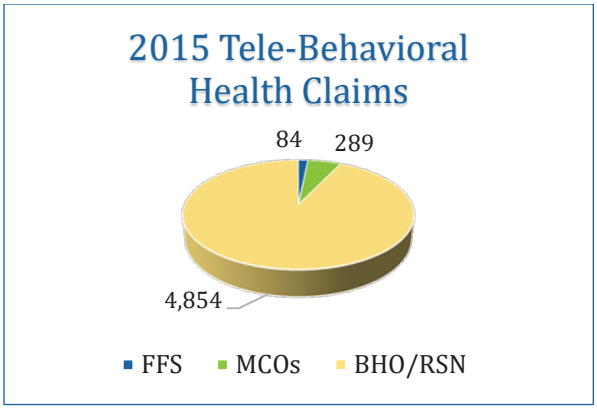
The majority of tele-behavioral health visits were classified as outpatient visits for an established patient, psychotherapy, or psychiatric diagnostic interview exams. The types of providers who used tele-health for behavioral health care included psychiatrists, psychologists, counselors, general practitioners, physician assistants, and advanced registered nurse practitioner (ARNPs).

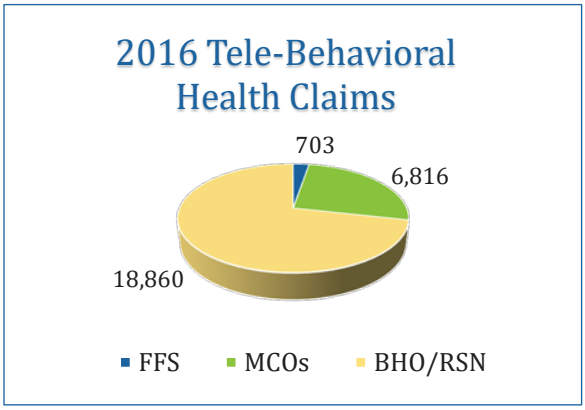
Medicaid Tele-Behavioral Health Visits				
YEAR	CLAIMS	CLAIM LINES[8]	TOTAL PAID[9]	CLIENTS SERVED
2015	5,227	5,439	$33,914.33	1,460
2016	26,379	26,676	$475,501.3	5,516

CY 2016 saw a significant rise in the utilization of tele-behavioral health services. The increased utilization may be related to changes in state laws addressing tele-health and/or increased awareness of the service option. As state behavioral health systems are undergoing significant transitions, numerous factors may contribute to the higher volume of tele-behavioral health visits. These factors include reduced costs and increased conveniences for both patients and providers that are afforded by tele-behavioral health services.[10] Effective April 2016, HCA implemented Fully Integrated Managed Care (FIMC) in Southwest Washington. At the same time, Department of Social and Health Services also transitioned from regional support networks (RSNs) to BHOs in the remainder of the state, which also may have affected utilization.



[8] A single service line item within a claim request for payment of Medicaid services
[9] Does not include costs for BHOs/RSNs
[10] Considerations for Planning and Evaluating Economic Analyses of Telemental Health. 2013. Luxton, D. D. Psychological Services.





As seen above, the majority of increases in claims in 2015-2016 occurred in the BHO/RSN system. See Appendix A for additional detail.

Medicaid Tele-Behavioral Health Visits					
YEAR	**BUSINESS**	**CLAIMS**	**CLAIM LINES**	**TOTAL PAID**	**CLIENTS**
2015	Fee-for-Service	84	131	$5,818	50
2015	Managed Care Organizations	289	454	$28,097	137
2015	Behavioral Health Orgs./ Regional Support Networks	4,854	4,854	-[11]	1,279
2016	Fee-for-Service	703	797	$23,746	201
2016	Managed Care Organizations	6,816	7,019	$451,756	1,346
2016	Behavioral Health Orgs./ Regional Service Networks	18,860	18,860	-	4,030
2015-2016	**All**	**31,606**	**32,115**	**$509,417**	**7,043**

The Medicaid MCO and FFS dollars spent in 2015-2016 on tele-behavioral health are a minimum of $509,415. However, this amount is only a portion of the total Medicaid dollars spent. The BHO/RSN dollars are not included in this total, since costs associated with BHO/RSN claims are not tracked by ProviderOne.

Since tele-psychiatry is a subset of tele-behavioral health, in which services are provided by a psychiatrist, these clients and claims are included in the tele-behavioral health total. Specific to the

[11] Costs associated with BHO/RSN claims are not tracked by ProviderOne.

subset of tele-psychiatry, 614 clients received 1,343 tele-psychiatry services through either FFS, MCO, or the BHO/RSN systems during 2015-2016.

Data Limitations

The data sets and associated analyses depend on the quality of the claims and encounter data in the ProviderOne payment system (the Washington State Medicaid Management Information System). The identification of tele-behavioral health depends on specific International Classification of Diseases (ICD) codes being present on the individual claims. In the clinical practice setting, some diagnoses may be overlooked or misidentified. FFS, MCOs and BHOs may have different coding patterns that affect the data. Finally, all claims and encounter data are subject to potential human error during entry.

Another notable limitation is the fundamental difference between what MCOs report in their encounters versus what BHOs report. MCO encounter data is, in essence, claims data for Medicaid-eligible clients. BHO data, on the other hand, is not a means of reporting claims payments but rather a way to report services delivered to any eligible client. Therefore, the system editing requirements are applied differently to each type of encounter.

Because of this fundamental difference in what is being reported, BHO/RSN-specific data may have additional limitations. Duplicate claims may be present in the data set; however, these claims may not represent duplicative services or services that are payable by Medicaid. In the BHO/RSN data, there are 2,816 instances in which a client has multiple claims on the same day for the same procedure code. Because of the differences of what encounter data is intended to represent in MCOs versus BHOs, and because claims dollars are not included in that data, it is difficult to accurately compare the two datasets when evaluating the utilization. Additionally, costs attributed to BHOs are not included; state data systems do not currently require BHO costs including, but not specific to, tele-behavioral health.

Conclusion

Though current billing system limitations do not allow for complete analysis of all utilization and cost, the use of tele-behavioral health appears to be increasing in the Washington Medicaid

population. There may be opportunities to further increase utilization of tele-health and improve access to behavioral health care. Barriers for providers to offer tele-health services may include:

- Challenges adapting to new practice patterns;
- Outdated or inadequate technological infrastructure;
- Inability to meet the quality and data privacy requirements;
- Lack of understanding of system and billing requirements[12]; and/or
- Regulations and business models that rely on encounter-driven, cost-based reimbursement that do not incentivize the use of tele-health services.

In addition to the technology, providers must follow established standards for conducting telemedicine visits, as detailed by the Medical Quality Assurance Commission.

Recent state laws[13] and community forums, such as the Washington State Telemedicine Collaborative[14], may help to increase access to and utilization of tele-health. Additional resources including training materials[15] and best practices may support provider adoption and utilization of tele-health. The Health Care Authority will address this topic in further detail in the 2018 legislative report required by RCW 74.09.325(9).

[12] Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced? 2013. Cynthia LeRouge, et al., Int J Environ Res Public Health.
[13] Senate Bill 5175, Senate Bill 5436.
[14] Washington State Telemedicine Collaborative
[15] Washington State Tele-Health Implementation Guidebook. 2017. Luxton, D. D. Department of Social and Health Services.

Appendix A: Client Diagnoses Associated with Tele-Behavioral Health

2016				
Rank	**Dx Code**	**Diagnosis–Short Description**	**Claim Lines**	**Clients**
1	F1120	Opioid Dependence, uncomplicated	6,803	1,157
2	F4310	Post-Traumatic Stress Disorder, unspecified	2,919	618
3	F331	Major Depressive Disorder, recurrent, moderate	1,447	374
4	F913	Oppositional Defiant Disorder	1,367	123
5	F209	Schizophrenia, unspecified	1,303	313
6	F250	Schizoaffective Disorder, bipolar type	942	183
7	F902	Attention-Deficit Hyperactivity Disorder, combined type	862	172
8	F332	Major Depressive Disorder, recurrent, severe with psychotic symptoms	751	232
9	F319	Bipolar Affective Disorder, unspecified	679	199
10	F251	Schizoaffective Disorder, depressive type	484	111

Note: Definition of tele-behavioral health is claims and encounters for tele-health services identified by GT modifier (a code used to identify tele-health) provided by a credentialed provider and focused on behavioral health care (treatment for mental health and/or substance use disorders). Behavioral health care visits were identified by a list of 2,498 International Classification of Diseases (ICD-9) and (ICD-10) diagnosis codes, specific to mental health and substance use disorder-related diagnoses.