Chapter 14
Resources on Funding, Economic/Cost Assessment, and Reimbursement

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Introduction

Economic stability of telehealth programs has fundamentally always been a challenge. From the early 1990s when the Office for the Advancement of Telehealth (OAT) in the Health Resources Services Administration (HRSA) in Washington, D.C., funding telehealth grants for rural health care providers, to today, health care organizations often struggle to appropriately quantify costs and revenues and use business models and strategies that create a sustainable and meaningful virtual care program.

Knowing the business model and the financial model is important to identify resources that will help with funding the initiative and then resources and revenues to sustain and maximize the Telemental Health initiative. How to determine a business model, financial model and where to find start-up capital is often a challenge for organizations just getting started with virtual care initiatives. The options also differ in terms of the type of virtual care to be delivered – live interactive traditional telemedicine, remote patient remote monitoring (RPRM), or asynchronous options such as texting, use of patient portals, or email. This chapter provides a guide to real world experiences and resources to help organizations be successful in their start-ups, particularly in underserved or rural areas. The resources highlighted in this chapter have been selected for their longevity in the telemedicine industry and their noncompetitive position on advancing telemedicine for underserved and rural populations, as well as for innovative thinking and strategic approaches.

This chapter provides a real-life, nuts-and-bolts, lessons learned approach to: (1) find and use resources to create a business approach based on economics of health care; (2) compare estimated versus real costs; and (3) maximize reimbursement.

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Case Study
Developing a Telemental Health Program for a Rural Outpatient Clinic a rural health care system comprising of a rural hospital (non-CAH), an outpatient center for procedures, and an outpatient clinic with family medicine, internal medicine, and a pediatrician. The health care system nor the local community had no mental health services available. A large mental health group in an urban area 125 miles away in the same state offered telemental health services. The rural facility desired to contract with the larger mental health provider for telemental health services. However, the rural facility had no experience with either providing or contracting for mental health services. Where to begin? The mental health provider needed to consider capacity, pricing model (per member per month, per click, fee-for service) and level of practitioners available and necessary to meet the service demands. Throughout this chapter, referencing to this case study will occur, leading the reader through an example in each area, of how to approach starting a telemental health program in each of the key subject areas. Look for "Case Study Implications" for the extended discussion.

Getting Started

Getting started with a telemedicine or virtual care initiative in 2021 is easier than ever since the global pandemic forced health care into the virtual world. Naysaying health plan payers as well as government payers suddenly waived restrictions and gave the United States the opportunity to see the full capacity and value of telemedicine and virtual care options. Not coincidently, many companies started to position themselves as "experts" in the field of virtual care and offered for fees to help organizations start a virtual program. However, there are tried and true options for getting assistance for any telemedicine or virtual care implementations.

Leading Telehealth Organizations

There are many organizations using all models of telehealth (traditional, online, concierge, asynchronous (chat, email, texting), RPRM, self-help, and artificial intelligence) that have been in existence since the early 1990s. These telehealth leadership organizations have lessons learned that go far beyond what consulting companies might be able to provide. Certainly, these organizations also have experienced the legal and regulatory environments and changing policies that provide expertise greater than what a law firm might provide as well. Telemental health programs often can learn from leading telehealth organizations that provide multispecialty services, acute care services, and many of these organizations also provide mental health, psychiatry, acute psychiatric hospital coverage, and crisis mental health services.

One example of a leading telehealth organization is the Cleveland Clinic's Center for Digital Health and Telemedicine (Cleveland Clinic, 2021) and the Center for Healthcare Delivery Innovation. The Center for Digital Health and Telemedicine aims to bridge the gap between digital health technologies and clinical practice. The Center focuses on research and education on technologies and wearable devices and provides guidance to patients and health care providers and the community at large (Cleveland Clinic, 2021). The Center for Health Care Delivery Innovation evaluates issues in health care delivery from the perspective of patients and health care providers and encourages and seeks out innovative strategies (Cleveland Clinic, 2021).

John Hopkins Telemedicine Center (John Hopkins Medicine, 2021) is another option for a long-standing successful telemedicine program. With a long history of telemedicine innovation, John Hopkins has one of the longest list of services provided to new and existing patients and has been a leader in educating the nation in all areas of telemedicine.

Dignity Health (Dignity Health, 2021) has particular experience in all aspects of virtual care including teleICU, TeleStroke, and many of the outpatient specialty services as well as RPRM. Dignity Health serves urban and rural areas in Nevada, Arizona, and California with primary and specialty care services via virtual care.

Additional organizations include Integris (Oklahoma) and Mercy Health (Missouri). Calling any one of these organizations and asking for the Telehealth Director or Clinical Coordinator will get the caller an expert in telemedicine initiatives and often will be the link to the telemental health expert in the organization.

Leading Telehealth Experts

Many of the authors in this book have been in the telemedicine and telemental health industry for years. Any of the authors are more than willing to help organizations, either through an informal conversation or a formal consulting arrangement, to start the telemental health program on a foundation that leads to success and sustainability. Calling on any of the telehealth names one might find on an internet search also will provide the telemental health startup program with an experienced telemedicine or telemental health professional that most times is more than willing to help and answer questions.

In addition, there are other nonprofit telehealth organizations that bring together technology, health care providers, innovative strategies, and broadband providers to help leverage telemedicine and telemental health in rural and underserved areas. One of the best is Palmetto Care Connections in South Carolina (Palmetto Care Connections, 2021). Professional associations also have a plethora of information to help members start telemedicine and telemental health initiatives. The American Medical Association, the American Psychiatric Association and the American Psychological Association all have white papers, position statements and resource pages on their websites that can assist and guide decision-making for the new telemental health provider.

Telemental Health Experts

The current world of telemental health is an interesting one indeed. With the proliferation of for-profit telemental health companies and the legal and regulatory requirements to have mental health services available, it is sometimes difficult to find an existing telemental health provider who is willing to assist a telemental health service start-up. Of particular difficulty is finding a resource to assist a, fee-for-service telemental health program that desires to bill insurance and not just collect cash payments from patients.

Resources that might assist that have no competitive interest are the Substance Abuse and Mental Health Services Administration (SAMHSA, 2021), the National Institute of Mental Health (NIMH), or organizations like mentioned above, the American Psychiatric Association (APA, 2021) and the American Psychological Association (APA, 2021). The Anxiety and Depression Association of America (ADAA, 2021) has many resources for providers and excellent tips for families and patients on selecting a telemental health provider that are exceptional guides for telemental health providers looking to understand the patient's perspective. The Telebehavioral Health Institute (TBHI, 2021) is an organization specifically focused on remote virtual behavioral health and includes many of the nation's top experts in telemental and telebehavioral health as consultants, advisors, and leaders of educational programming.

Certificate Programs

Another option for learning how to start a telemental health program is a certificate course that results in certification or a knowledge certificate (proof of attendance) in telemedicine or telehealth. Although these courses cover a variety of topics, some caution should be used in the company's background, the speakers, datedness of the material being presented, etc. Certification is not required for a telemedicine program nor a telemental health program for any type of legal or regulatory status or reimbursement. Certification for a program is more of a status symbol. However, some certificate programs are good learning experiences.

Make sure to look for a certification program from experienced provider organizations such as THBI, Cornell's Telemedicine Course (Cornell University, 2021), and other online courses such as those offered by the National School of Applied Telehealth through the Southeastern Telehealth Resource Center (SETRC, 2021), one of the few Telehealth Resource Centers focused on evidence-based and scientific researched telemedicine practice. Although not specifically telemental health, the SETRC is a good place to start to learn about telemedicine and receive CEU educational programming.

Case Study Implications The rural facility put together a small workgroup including clinicians, nurses, a business manager, legal services/compliance, and a

community advocate to begin the process of investigating how to bring mental health services to the rural community. The group conducted research on the internet and collected resources from SAMSA, Telehealth.org, the state Medicaid office, and from CMS. In looking through the information, the group created a weighted attribute list of characteristics of the program that were important to the community and fit the community's needs. Included in the list were the requirements for contracting, payment models, and metrics for success. Decisions included whether or not a 24×7 crisis intervention service, 7-day-a-week outpatient service, a Monday–Friday business hours outpatient service, or the mental health provider could choose their own hours model(s) were needed and which to select. The mental health provider in discussion would need to consider whether or not 24×7 services were available and if not what services could be reasonably accommodated during which hours of the day and days of the week. Pricing models would then need to be considered in order to determine break-even points (if applicable) and profit margins.

Getting Paid

Reimbursement and payment for services delivered by virtual strategies have often been problematic for telehealth providers. The global pandemic has revolutionized payment for services delivered via telehealth, especially for telemental health and substance abuse issues delivered to the home. Understanding the payment and reimbursement landscape, the differences between government payers, Medicaid plans, private health plans, and other payers of health care services is often mind-boggling for organizations. Documentation requirements to support coding and billing as well as tracking and auditing claims for services delivered via telehealth in a hybrid environment (in-person plus virtual) add an additional layer of complexity.

Government Payers: Medicare

The Centers for Medicare and Medicaid Services (CMS, Medicare) provides a comprehensive set of resources that provide Member Learning Network (MLN) dated memos that explain specifics related to telemedicine and telemental health. Both telemedicine and telemental health are treated the same with respect to payment from Medicare. Payment is authorized and amended through the annual Physician Fee Schedule submission process (CMS, 2021) The MLNs are also specific to the area of telemedicine services. The annual MLN describes current and future approved telemedicine services based on the new Physician Fee Schedule that includes the originating site, eligible practitioner, geographic restrictions, and CPT codes approved (pp. 3–6). Specific MLN Matters might include notices such as the New/Modifications to the Place of Service (POS) Codes for TeleHealth (p. 1) or Transitional Care Management Services that outlines the use of telehealth and

qualified practitioners as well as delegated activities (CMS, 2021). There are no specific MLNs related to telemental health. For CMS and Medicare, telemental health is covered in the general guidelines.

Government Payers: Medicaid

Medicaid agencies in all states and territories have unique payment policies specific to that state. It is important for the telemental health provider to review on a monthly basis current policy and any proposed changes to reimbursement policies for telemedicine or telehealth. Often states will have separate payment policies for telemental health as mental health services are one of the earliest services to be provided by telehealth (starting in 1954). Mental health providers should search their Medicaid website for telehealth *and* telemental health payment and reimbursement policies, the state's Office of Insurance Commissioner (or similar), and the Consumer Protection Agency or Office in the state for all possible payment requirements. In addition, many states have telehealth parity laws. These telemedicine parity laws are again, all dissimilar and waiver from equal access and payment for all services under the health plan (including Medicaid managed care organizations and Medicare Advantage plans) to those parity laws that do not mandate anything. The telemental health provider should understand any telehealth parity law for the target state and any telemental health provisions. Often, the use of a reimbursement specialist or corporate attorney may be useful in understanding the legalese used in the legislation. Do not overlook regulatory language as well. Legislation is the law that is intended to set the stage for payment. Regulatory language is the conditions and language that describes the terms of implementing the law. Often, there is a discrepancy between the legislated intent and the regulatory outcomes.

Private and Self-Pay

Private payers and patients should be billed. Simple as that! Payers in a telehealth parity state do not have the option of not paying or paying less in a state with equal access and equal payment if the benefit is a covered benefit when delivered in-person.

For non-parity states, telemental health providers should bill all private health plans and then deal with denials as those denials come in. Knowing which private health plans pay for services and when those payment policies change is often again, cumbersome. The telemental health provider's revenue cycle management department or outside contracted service should have automated updates and, at a minimum, someone watching for changes in private payer payment policies, particularly reduction in payment for virtual care services.

For patients that are self-pay, and the service is provided in a traditional manner, the same billing process should be used for those patients who pay out-of-pocket.

Claims go through the standard process and either go to payment, collections, charity, or bad debt based on the telemental health provider's debt collection process.

Case Study Implications The rural health care system's case mix was 30% Medicare, 60% Medicaid, and 10% self-pay. In considering the financial implications of contracting for a service, the organization had to consider the financial impact on the budget. Two models exist for contracting in a mixed payer environment. The rural health organization could pay a contractual fee to the mental health provider, who would transfer assignment to the rural health system to be able to bill for the services. The rural health system then could recoup some of the contractual costs of purchasing the services for the community.

Staying out of Jail: Legal and Regulatory

There are many areas of legal and regulatory importance for the telemental health provider. The applicable legal and regulatory issues vary widely between modalities of telehealth and between state and federal policy and state-to-state policy. The regulation of telehealth varies by the setting and type of program. Regulators and policy-makers are concerned about the consequences of the lack of a direct clinical setting and the potential lack of jurisdictional reach. Accordingly, standards of care and licensure (and corollary concepts of other agencies such as the Food and Drug Administration (FDA) have been a primary focus of regulatory development and interest to telemental health providers. Legal and regulatory issues fall into several different categories: Licensure, Clinical Practice, Exam Requirements, Prescriptive Authority (Controlled Substances), scope of practice and practice board authority, reimbursement, supervision, and other issues.

What is of importance for the telemental health provider is to use a team of experts in clinical practice, legal affairs, and compliance to ensure that all legal and regulatory questions are answered before starting a telemental health practice. A few caveats are noted below for each area.

Licensure

For all practical purposes, a clinician must be licensed in the state in which the patient resides at the time of the telemental health visit. There are really no special telemedicine or telehealth licenses, just the standard license that would be issued for in-person or in-state resident practice.

There are different ways to accomplish such licensure requirements depending on the professional degree. During the global pandemic, full licensure requirements were waived or relaxed for physicians, but not for many other health professionals. Licensure for physicians can be accomplished through the Interstate Medical

Licensure Compact Commission (ILMCC, 2021) or by applying individually to each state in which the physician will see patients via telehealth. Licensure for Advanced Practice Professional (APP – Advanced Practice Registered Nurses, Physician Assistants, Certified Nurse Anesthetists, Midwives) mental health providers is more complicated with each of the states having a different set of requirements for licensure to practice via telehealth. An APP must look at each state and meet that state's requirements for collaborative practice agreements and supervising clinicians before a license can be obtained to see patients via telehealth. All other health professionals, social workers, licensed clinical psychologists, licensed counselors, must also check each individual state for the requirements to practice and licensure via telehealth.

At this writing, there are several licensure compacts that help facilitate licensure portability for practice via telehealth. Registered nurses have the Nurse Licensure Compact (eNLC, 2018) through the National Council of State Boards of Nursing. Psychologists have the PSYPACT (2015) that allows a psychologist to practice telepsychology and/or conduct temporary in-person, fact-to-face practice in participating states. Physical therapists, EMS personnel, and speech and language therapists also have active interstate licensure compacts.

Clinical Practice

The patient–provider relationship exists in a virtual environment and all aspects of clinical practice apply when the patient is seen via telemental health. The clinician must maintain standards in practice and uphold the appropriate scope of practice. In addition, the clinician must understand the environment of care and the patient–provider relationship. Clinicians must feel comfortable in practicing telemental health and understand the limits to such practice. The scientific literature is very positive in terms of clinical outcomes for the mental and behavior health sciences when telemental health is used, but, for some patients and some situations, telemental health may not be appropriate. The bottom line is that the clinical practice does not change from in-person care when telemental health is used. The clinician is still responsible for the same level of assessment, evaluation, plan of care, intervention as in-person care and also, to know when telemental health is not being effective and to stop and schedule the patient for in-person care.

Scope of Practice

The Scope of Practice again does not change simply because the telemental health provider is using virtual care strategies. The telemental health providers still must know how the scope of practice for each health professional is defined, who regulates the scope of practice, and if there are any situations in which the scope of

practice might change or become more restrictive if telemental health is being used. The ability to prescribe controlled substances is one of the few areas in which scope of practice does change when telemental health is used. In addition, during the global pandemic, several components of scope of practice were waived to allow clinicians to better serve populations with COVID19. Telemental health providers especially, must be aware of the date when the emergency orders for the pandemic expire to ensure adherence to scope of practice requirements.

Ethical Conduct

The use of telehealth does not remove any existing responsibilities in delivering services, including adherence to the Code of Ethics, Scope of Practice, state and federal laws, and professional association documents on professional practice, and the quality of services must be consistent with the quality of services delivered [face-to-face].

Physical Exam Requirement/In-Person Visits

Some state laws and federal regulations for prescribing controlled substances require the patient to be seen in person or to have a physical exam conducted in-person prior to using telehealth or writing prescriptions for controlled substances. Some of these laws are simply to keep out online urgent care companies and others are intended to protect patients from unscrupulous online pharmacies. Unfortunately, these laws inhibit the ability of telemental health providers to completely and adequately serve their population through telemental health. Mental health clinicians typically do not do a physical exam and, therefore, could not meet such a requirement before using telemental health. The question of what constitutes a physical exam for a patient with mental health issues is also unanswered by policy-makers. Having an in-person visit prior to writing a prescription for a controlled substance is also impractical and at times unfeasible, and defeats the purpose of using telemental health as a tool for access for remote, rural, and underserved populations. If the population could get an in-person visit, the population most likely would not need telemental health.

With respect to remote prescribing, the same principles for in-person care apply. Does the patient need a prescription? What is the prescription for? Can the prescription be delivered electronically through a secure e-prescribing system? There are different methods that can be used depending on the patient's location and the type of medication being prescribed to get the prescription to the patient. The prescription can be generated and sent to the pharmacy electronically, called into the pharmacy by the health care professional's office staff, a paper prescription can be mailed to the pharmacy or the patient, or the telemental health provider can

recommend a course of medication therapy to a primary care provider who then writes the prescription (particularly in the case of controlled substances). If the substance is a Schedule II, III, IV, or V substance, specific regulatory requirements must be met including a special controlled substance DEA license before such prescriptions can be generated (DEA, 2020). Each state also has specific requirements for controlled substances and DEA registrations. There are also specific waivers during the global pandemic for the prescribing of controlled substances via telemental health (Health and Human Services, 2020a).

Legal and Regulatory Resources

There are many resources available to the telemental health provider to research, know, and understand the legal and regulatory issues surrounding the use of virtual care strategies. All of the authors listed in this book also are experts in legal and regulatory issues in telemental health. Some additional resources are included below:

1. Rural Health Information Hub – The Rural Health Information Hub, formerly the Rural Assistance Center, is funded by the Federal Office of Rural Health Policy to be a national clearinghouse on rural health issues and is committed to supporting healthcare and population health in rural communities (ORHP, 2021) The Legal and Regulatory Toolkit for Implementing a Telehealth Program is a comprehensive resource for listing the items to be considered
2. Health and Human Services, Washington D.C. – Telehealth for Behavioral Care is a comprehensive summary of elements for starting a telemental health program, billing, and preparing patients for telemental health (HHS, 2021)
3. Substance Abuse and Mental Health Services Association (SAMSA) – The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities (SAMSA, 2021) SAMHSA has published a guide for using telehealth modalities for serious mental illness and substance use disorders (SAMHSA, 2021)
4. Telehealth.org (Formerly TBHI) is a comprehensive website that has been focused on legal telehealth compliance and ethical telehealth practice since 1994. Resources include international, interprofessional faculty, 100% online, self-paced, self-directed training, industry leaders in legal, ethical, technical implementation, CME and CE hours available for 14 disciplines, as well as books, articles, papers, and other peer reviewed literature (telehealth.org 2021)

Case Study Implications The rural health system identified licensure, level of professional practice (Psychiatrist, Licensed clinical psychologist, etc.) and therapeutic evidence-based practice requirements as key elements in the contractual relationship. Background checks including the National Practitioner Data Bank, the

National Sex Offender Registry, and other necessary checks are requirements of the mental health provider organization. Specific levels of insurance, dual-indemnity clauses, and other required Business Associate Agreement (BAA) were also identified as important in the contract language and terms. The rural health provider also sought the advice of outside counsel to review the contract language and to assist with any redlines from the potential mental health provider. The mental health provider has its own BAA but did have policies in place that would accept with review the terms and conditions in the contracting organization's BAA.

Prescribing of controlled substances if needed was an area that took some discussion to find a workable solution with which local primary care providers were comfortable and that worked for the prescribers. Several options existed. As the mental health provider could use one of the DEA exceptions, that the patient was in a facility with a DEA licensed provider and the facility was registered as a DEA facility, the prescriber could write a controlled substance prescription as a result of a telemental health visit (DEA rules in force as of 10-2021. For current rules, go to www.Dea.gov at the time of reading). The prescriber could also write a medical note to the primary care referring provider and indicate recommendations for drug therapy and the local primary care provider could write the prescription. Many primary care providers are not comfortable with writing prescriptions for controlled substances to treat mental health conditions, but with the input and monitoring of the prescription and drug therapy by the mental health team, many primary care providers have taken on this role. In the case study, the mental health provider chose to write the prescriptions as long as the patient was seen at the local health care system physical location. Any patient seen at home for the telemental health visit would have to see their primary care provider for prescriptions for controlled substances.

Financial Validation of a Telemental Health Program

Creating a meaningful fiscal valuation of a telemental health program as well as understanding the cost burden and whether or not the program adds to the bottom line of the organization is at times challenging. The typical return-on-investment or break-even analysis simply do not work for a telemental health program. What is more important is to understand the actual costs of the program as well as the cost avoidance, cost reduction, and utilization of high cost access points.

One of the best ways to determine how much a telemental health program costs is to use activity-based costing. Activity-based costing is a method to calculate the actual cost of an activity based on the number and type of resources consumed. This model uses the financial calculations of all costs associated with the activity (one telemental health visit). The most common financial calculation used by health care organizations is revenue over expense. However, a revenue over expense calculation does not consider actual resources consumed by a single activity (one telemental health visit), rather, calculates all expenses incurred applied to all revenues earned.

Calculating how much a single telemental health visit costs considers all activities and resources consumed in that one activity. For instance, in a 50 min telemental health visit, (activity), one would calculate the costs associated with the resources used (practitioner, nurses, telepresenters, EHR, reception, scheduling, technology, etc.), broken down into 1 min increments. The following table is an example of calculations based on activity-based costing of a telemedicine consult versus an in-person visit (Table 14.1) (Antoniotti, 2004).

One can see that providing services to patients over telemental health costs less as an activity than seeing the patient in person. Even when one pays for the patient site support staff (person assisting the patient at the patient end) in situations where the same corporate entity owns both locations, the costs are still comparative to in-person care (adding back in the support staff costs at $23.45 [45 min of time] only raises the costs $7.79, which is significantly lower than the costs associated with outreach). In addition, providers who use traditional telemedicine interspersed into their daily in-person schedule, see more patients per clinic day than in physical outreach, which decreases the number of hours in an outreach clinic day due to travel. If one considers all these factors, the financial impact of using traditional telemental health, especially if the telemental health provider is at home providing the service, is less of a financial burden on the organization than in-person care.

Conducting outreach has the same implications when using activity-based costing. If an organization were to evaluate its outreach using an activity-based costing model, the results would show that the revenue produced by the outreach activity does not cover the actual costs of the outreach activity. In an example of calculating a 30 min telemedicine visit versus a 30 min in-person visit, the results indicate that the in-person visit costs $154.32 and the telemedicine visit costs $141.66, a cost savings of $12.66. Multiplied by thousands, and the cost reduction becomes significant. Outreach may be necessary and ethically the right thing to do. The organization's care delivery goal is to reduce physical outreach but maintain presence and patient–provider relationships through the use of telemental health, but the financial goal is cost reduction.

Table 14.1 Activity-based costing comparison of in-person vs. telemedicine visits – 15 min

Resources	In-person	Telemedicine
Psychiatrist – average salary per hour = $250 = $4.16 per minute	$125	$125
Support Staff – average salary + benefits = $65,000 = $.52 per minute	$15.66	$0
Scheduling/Reception – average salary $35,000 = $.28 per minute	$8.41	$8.41
EHR Costs	$.25	$0.25
Technology software license	$0.00	$1.00[a]
Patient Site Staff Costs	$0.00	$0.00[b]
Indirect Costs[b]	$5.00	$2.00
Total	$154.32	$141.66

[a]Cost for concurrent use video license per use

[b]Indirect costs are always lower when telemedicine is used as the exam rooms, consumables, HVAC, etc., are not consumed as the patient is not present

Break-even analysis often does not work as a financial model for telemental health. Revenues are often poor and the time commitment is typically much greater than medical or surgical specialties or urgent care online programs. If revenue is $56 per visit, activity-based costing shows that the costs are $110 per visit, the organization is already at a loss. Considering the number of widgets per hour is not an appropriate model of productivity to use for telemental health. The value of activity-based costing is the real true data that reflects where cost savings, cost reduction, and cost avoidance strategies will have the greatest impact.

Activity-based costing is also of value when contracting for telemental health services. If a contract is being negotiated for a per visit or hour fee, the telemental health provider needs to know where to set the price in order to have a margin. If the cost is $75 per hour and the fee charged is $60 per hour, obviously, the telemental health provider is going to lose money. Pricing on a model of per patient per month also has disadvantages. Typically, pricing based on a fee per click (visit) is the optimum financial model for a contractual telemental health service. A contractual hourly rate is also a good financial model when the costs per hour are accurately calculated.

For instance, if a telemental health provider is considering providing services to a health plan, primary care practice, or a government agency, selecting a per-click fee or a per-member-per-month (PMPM) fee can either make or break the financial outcome. The following example shows how the difference between a per-click rate and a PMPM fee structure causes the bottom line to shift.[1] Using the capitated PMPM rate, the telemental health organization loses money using either a physician or nurse practitioner. Using the per-click rate, the telemental health organizations achieve positive revenue. The same will hold true for other mental health professionals who may provide the contractual services (Table 14.2).

Case Study Implications The mental health provider used activity-based costing to determine the actual cost of each activity (outpatient scheduled visit, on-demand crisis intervention) and then could reasonably set pricing based on covering costs and achieving a profit margin. There are differences between per-click rates and per-patient-per-month rates and the telemental health provider chose per-click rates as being more closely tied to covering costs and creating a small profit margin. The rural health system decided to use a certified medical assistant for the receptionist, vital signs, and information sharing/patient check in functions of the telemental health clinic. This level of certification provided the legal authority to provide information to the mental health providers (vital signs) and also do medication list checks prior to the visit.

[1] Antoniotti, 2019. Unpublished presentations.

Table 14.2 Comparison of payment options for telemental health contracted services PPM vs. per-click rates

Capitated PMPM Rate
$7.00 per employee per month
1000 employees = $7,000 revenue
Time spent in online care visit = 7–11 min
50% of employees call in one time per month
Payment to physician = $12,500
Payment to NP = $9,000
Software costs = $7 per click = $3500
Total costs MD covering = $16,000 (−$9,000 per month)
Total costs NP Covering = $12,500 (−$5,500 per month)
Per Click Rate Fee Structure
$49 × 500 = $24,500 revenue
Total costs MD covering = $16,000 ($8500 per month)
Total costs NP covering = $12,500 ($12,000 per month)

Conclusions

The case study shows an example of all the components necessary to achieve a successful telemental health program from the start. Although the finite details are covered in other chapters, one can see that an organized approach, with a team of key stakeholders, armed with accurate and legitimate information, can create a business plan around implementing a telemental health program. This business plan is similar to and as successful as implementing any other health care service, as long as the homework is done and all questions answered.

Key metrics for any telemental health program are different at key stages in the program. Pre-implementation should identify a checklist and ensure that the checklist is completed and all key stakeholders are in agreement with the implementation plan and clinical, financial, technology, and outcomes metrics. Implementation measures how well the program was implemented, were there any course corrections in the first few weeks of implementation, and whether or not clinics ran on time, patients and providers were able to connect on time and without issues, did visits go well with no technological interruptions, were there any untoward events (lack of crisis plan, inability to get ahold of the telepresenter or provider, etc.), etc. Evaluations include provider satisfaction for the telemental health provider with the program, the referral process, and the technology. For patients, satisfaction with telemental health, ease of access, etc., are important metrics for the patient experience. Financial metrics should be monitored weekly and include obtaining a weekly report of all consults including date of service, time of service, patient MRN, name, and DOB, provider name, CPT code and name billed, health plan billed, payment(s)

received including insurance payment, contractual discounts, patient payments, other discounts and write-offs to track which health plans are paying (are all paying in a state with telehealth parity laws?) and comparison to contractual amounts paid minus billable revenue collected (to determine actual cost of service).

Take home messages from this case study are (1) starting a TeleMental Health program can be easy or hard. Having a detailed checklist of all the items to discuss, investigate, research, decide, plan, and then implement can make the process much smoother and prevent bumps in the road for missed areas of planning. The financial components of reimbursement, capital funding, start-up costs, sustainability, and financial success metrics are key to success; (2) Resources are available through national agencies such as CMS, SAMHSA, ORHP, as well as Telehealth Resource Centers, other telehealth programs, and national experts who have worked in the field for years. Having a good source of information and advice is one of the most valuable components of implementing a TeleMental Health program. Ensuring that the financial discussions are concrete, backed by data, and take an innovative approach helps to create a sustainable well-funded program; and (3) Don't be afraid to ask for help. Even the most experienced TeleMental Health providers have questions in an ever-changing legal and regulatory environment. Keep the patient in the center of all decisions and ensure that all questions are answered in a manner that fits into the mission and vision of the organization. If it does not feel right, it is not right!

The laws and regulations governing telehealth are fast-changing, but deregulation in certain key areas to promote the advancement of telehealth programs is occurring.

There are tried-and-true pathways to complying with the applicable legal and regulatory requirements – but all pathways require ongoing monitoring and assessment. Some final words of wisdom for the telemental health professional to stay out of trouble is to be confident of your clinical programs; be sure to check your facts regularly; involve the team when necessary regarding legal and regulatory questions; and know your legal friends and enemies!

CE/CME Questions

1 What is the best method to get assistance when starting a new TeleMental Health initiative?

(a) National mental health organizations
(b) Telehealth Resource Centers
(c) Office for Rural Health Policy
(d) Other telemental health programs
(e) Trial and error

2 What legal and regulatory policies need to be reviewed prior to starting a TeleMental Health initiative?

(a) Licensure, ethical practice, DEA prescribing, patient preferences
(b) Licensure, insurance benefits, patient internet options
(c) Licensure, ethical practice, medical staff requirements, Joint Commission
(d) State licensing requirements, practice board rules, ethical practice, scope of practice
(e) Joint Commission requirements

3 Activity-based costing is important to Telemental Health in that the accounting approach:

(a) Identifies where a provider is inefficient
(b) Identifies where an organization can make money
(c) Helps an organization understand the real costs of providing health care
(d) Points out where organizations can cut costs
(e) Makes the provider compliant with billing

4 Physical exam requirements for telemedicine visits:

(a) Vary by state
(b) Are the same as in-person care
(c) Must be documented in the record the same as in-person care
(d) Do not have to be done for any telehealth visits
(e) Should be completed by the lowest level licensed practitioner

5 Getting paid for services delivered by Telemental Health depends on: (check all that apply)

(a) The payer source – government (Medicare, Medicaid, private health plans)
(b) The eligible practitioners
(c) Approved services to be delivered via TeleMental Health
(d) Patient insurance benefits
(e) State-based telehealth parity laws

Answers

1. (d)
2. (d)
3. (c)
4. (b)
5. (a)

References

Anxiety and Depression Association of America. https://adaa.org/. Accessed 09 Feb 2021

American Psychiatric Association. (2021). *What is telepsychiatry?* https://www.psychiatry.org/home/search-results?k=telemedicine

Center for Medicare and Medicaid Services. (n.d.). *Telehealth services*. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Services. Accessed 02 Feb 2021

Centers for Medicare and Medicaid Services. (n.d.). *Telehealth criteria*. https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Criteria. Accessed 02 Feb 2021

Center for Medicare and Medicaid Services. (2021). *2022 Physician fee schedule – Final Rule. Federal Register, Nov 2, 2021*, pp. 65047–65062.

Centers for Medicare and Medicaid. (2021). *New/modifications to the place of service (pos) codes for telehealth. MLN Matters: MM12427, Oct 14, 2021*, pp. 1–2.

Centers for Medicare and Medicaid. *Transitional care management services. MLN Matters 908628, July 2021*, p. 10.

Cleveland Clinic. (n.d.-a). *Center for digital health and telemedicine*. https://my.clevelandclinic.org/departments/heart/depts/digital-health-technologies. Accessed 15 Feb 2021

Cleveland Clinic. (n.d.-b). *Center for delivery innovation*. https://my.clevelandclinic.org/departments/heart/depts/healthcare-delivery-innovation. Accessed 15 Feb 2021

Cornell University Weill Cornell Medicine. https://online.cornell.edu/courses/healthcare/telemedicine/?creative=473157612475&keyword=%2Btelehealth%20%2Bcourse&matchtype=b&network=g&device=c&utm_source=google&utm_medium=cpc&utm_campaign=healthcareldrshp_US%20-%20Telemedicine&utm_term=%2Btelehealth%20%2Bcourse&utm_content=g_473157612475_b&creative=473157612475&keyword=%2Btelehealth%20%2Bcourse&matchtype=b&network=g&device=c&url=https%3A%2F%2Fonline.cornell.edu%2Fcourses%2Fhealthcare%2Ftelemedicine%2F%3Fcreative%3D473157612475%26keyword%3D%252Btelehealth%2520%252Bcourse%26matchtype%3Db%26network%3Dg%26device%3Dc&target=&position=&gclid=Cj0KCQjwkOqZBhDNARIsAACsbfKjZluyrfyfigfjRlKNsgi0VudSNs7X7WFk2L9DRZDErycoHUU5m58aAnLHEALw_wcB. Accessed 08 Feb 2021

Dignity Health. (2021). *About dignity health virtual visits*. https://virtualcare.dignityhealth.org

Drug Enforcement Administration. (2020). Electronic prescriptions for controlled substances. Federal Register, 85(77), 22018–22021.

Health and Human Services. (2020a). *Prescribing controlled substances via telehealth*. https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/prescribing-controlled-substances-via-telehealth

Health and Human Services. (2020b). *Introduction to telehealth for behavioral health care*. https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health

Health Resources and Services. (n.d.). *Administration Rural Health Information Hub. Telehealth use in rural healthcare*. https://www.ruralhealthinfo.org/about

Health and Human Services (n.d.). *Preparing patients for telebehavioral health*. Accessed at https://telehealth.hhs.gov/providers/telehealth-for-behavioral-health/preparing-patients-for-telebehavioral-health/. Accessed 06 Feb 2021

Health Resources and Services Administration Rural Health Information Hub. (n.d.). *Legal considerations for implementing a telehealth program*. https://www.ruralhealthinfo.org/toolkits/telehealth/4/legal-considerations

Interstate Medical Licensure Commission. (2021). *A faster path to physician licensure*. https://www.imlcc.org

John Hopkins Medicine. (2021). *Connecting patients to exceptional virtual care*. https://www.hopkinsmedicine.org/telemedicine

Maheu, M. (n.d.). *Training and certificates*. https://telehealth.org

National Council of State Boards of Nursing. (2018). *NLC model legislation and rules*. https://www.ncsbn.org/nurse-licensure-compact.htm

Office of Rural Health Policy. (2021). About the rural health information hub. Accessed at https://www.ruralhealthinfo.org/. Accessed 07 Feb 2021.

Palmetto Care Connections. (2021). *What is palmetto care connections?* https://www.palmettocareconnections.org

PSYPACT. (2015). *Legislative resources*. https://psypact.site-ym.com/general/custom.asp?page=PracticeUnderPSYPACT

Southeastern Telehealth Resource Center. (2021). *General telehealth resources*. https://setrc.us/resources/general-resources

Substance Abuse and Mental Health Services. (n.d.-a). *Medication assisted treatment*. https://www.samhsa.gov/sites/default/files/programs_campaigns/medication_assisted/dea-information-telemedicine.pdf

Substance Abuse and Mental Health Services. (n.d.-b). *About us*. https://www.samhsa.gov/about-us. Accessed 10 Feb 2021

Substance Abuse and Mental Health Services. (2021). *Telehealth and the treatment of serious mental illness and substance use disorders – evidence-based resource guide series overview*. Pub. No. PEP21-06-02-001, first release 2021. Health and Human Resources, Washington, DC

Substance Abuse and Mental Health Services. (n.d.-d). *CCBHCs using telehealth or telemedicine*. https://www.samhsa.gov. Weil Cornell Medicine. Telemedicine Cornell course eCornell. https://online.cornell.edu/courses/healthcare/telemedicine/?creative=473157612475&keyword=%2Btelemedicine%20%2Bcertificate&matchtype=b&network=g&device=c&utm_source=google&utm_medium=cpc&utm_campaign=healthcareldrshp_US%20-%20Telemedicine&gclid=Cj0KCQiAtJeNBhCVARIsANJUJ2HC8K_bR2sytUOnMu5_nlvSJ5KgS9kFCTFLKjWdeXIEqPCCJVnJ7mQaAhjOEALwwcB https://online.cornell.edu/courses/healthcare/telemedicine/?creative=473157612475&keyword=%2Btelemedicine%20%2Bcertificate&matchtype=b&network=g&device=c&utm_source=google&utm_medium=cpc&utm_campaign=healthcareldrshp_US%20-%20Telemedicine&gclid=Cj0KCQiAtJeNBhCVARIsANJUJ2HC8K_bR2sytUOnMu5_nlvSJ5KgS9kFCTFLKjWdeXIEqPCCJVnJ7mQaAhjOEALw_wcB. Accessed 10 Feb 2021

Telebehavioral Health Institute. https://telehealth.org. Accessed 08 Feb 2021