Telemedicine Is Wide-Reaching But Doesn’t Always Replace Doctor’s Touch

By Elaine Korry | July 7, 2017 | California Healthline

Two years ago, Kimberly Griffiths’ week-old daughter, Avery, suddenly became very ill. “She was turning blue and had very labored breathing,” said Griffiths, who rushed her child to the ER in rural Sonora, Calif.

Doctors there were stumped, and the nearest pediatric specialist was 100 miles away in Sacramento.

Fortunately for Avery, the ER doctors were able to make a two-way, online video connection to consult with a UC-Davis neonatologist, who viewed high-resolution images of the infant and her vital-signs monitor. The specialist suspected a congenital heart condition and prescribed a drug that stabilized her breathing.

“Without telemedicine, our daughter would have died that night,” Griffiths said. She was relieved that her family’s insurance company reimbursed the cost of the remote services her child received. “Nobody should be denied the health care they need because of where they live,” she said.

Use of telemedicine is exploding in California and other states as insurers increasingly cover tests and treatment overseen from afar. Forty-eight states and Washington, D.C., now provide reimbursement for some form of live video in Medicaid’s fee-for-service model.

Since 2015, Kaiser Permanente in California has served more patients each year through telehealth — a combination of online contacts and video conferencing — than through traditional visits. (Kaiser Health News, which produces California Healthline, is not affiliated with Kaiser Permanente.)

Still, regulators in this state and elsewhere have approached telehealth with caution.

Only a few states in limited circumstances allow insurance companies to count telehealth toward fulfilling their requirements for “network adequacy” — the number of physicians, hospitals and specialists mandated within a region to ensure the right care can be provided in a timely way within an acceptable distance. A plan’s adequacy needs to be approved before it can operate in the state, but the state will work with plans that fall short, according to California regulators.

In California, legislation passed in 2011 recognized telehealth as appropriate care and qualified some types of care, such as live videoconferencing, for coverage by insurers and by Medi-Cal, the state Medicaid program.

But regulators have been “limiting plans from being able to utilize telehealth to its fullest,” said Mario Gutierrez, executive director of the Center for Connected Health Policy in Sacramento, a nonprofit dedicated to integrating virtual technologies into the health care system. (The center’s founder and lead funder is the California Health Care Foundation; California Healthline is an editorially independent service of the foundation.)
Gutierrez said Medi-Cal does not reimburse at all, for instance, for remote monitoring of biometric measures, such as heart rate or blood pressure. Plus, Medi-Cal restricts reimbursement for the use of high-definition images sent online for examination or diagnosis.

Libby Baney, who follows digital health policy for Faegre Baker Daniels Consulting, said regulators’ positions on whether telehealth counts toward “network adequacy” are inconsistent. “The trend in states at the legislative level is to create access to telemedicine as a recognized care setting, and yet you’ve got regulators lagging behind,” she said.

Baney said she believes telehealth services should count toward network adequacy, but only for settings where it is appropriate, such as providing access to specialists in remote areas, and not as a “proxy for traditional in-person care.”

Charles Bacchi, president of the California Association of Health Plans, said that whether to count telemedicine toward network requirements is “a live debate, something we’ve been talking about for a couple of years.” Bacchi is hoping for a change in policy from regulators, so that providers of telehealth already being used by health plans will fulfill network requirements. For now, that’s not the case.

“We cannot in our network filings use those relationships to count as an actual provider ... to satisfy our network adequacy requirements,” said Bacchi.

Bacchi said he can’t imagine regulators ever allowing insurers to restrict consumers to using telehealth alone. “We have to, by law, provide face-to-face access.”

For now, most regulators consider telehealth on a case-by-case basis, as a helpful strategy in underserved areas. In an email, the state Department of Managed Health Care, which regulates most of the insurance industry, said it does this when providers are in short supply. “However, plans are not permitted to replace accessible brick-and-mortar providers with telehealth services.”

Meanwhile, some providers continue to see tremendous economic opportunity in telemedicine. They argue it serves busy consumers who value convenience and can fill gaps as insurance plans increasingly rely on narrower networks of providers.

Dr. Henry DePhillips, chief medical officer of Teladoc, the direct-to-consumer “virtual care” giant, said its network of providers includes 3,100 licensed physicians and therapists who are physically present in all 50 states. They have their own more traditional practices and work for Teladoc part time. “If you think about the network adequacy question, these are doctors that are already taking care of Californians today. They’re extending their reach by practicing telemedicine as well, so why would you not include them in the network adequacy scenario?”

Some patients say they prefer to see their doctors virtually, when feasible.

Gabriel Bruce of Richmond, Calif., is able to log on to the Kaiser Permanente website and consult directly with his primary care physician without the hassle of having to visit the doctor’s office.

“I don’t have a car, so I would have to take BART [public transportation] to a part of town that I’m not used to,” said the 19-year-old student. Access to the website could have been a little smoother, said
Bruce, but otherwise a recent interaction was a success. “It was very professional, and really convenient,” he said.

Other patients are still wary of telemedicine, fearing it could be used to cut costs and skimp on care. “They just want to reduce their overhead,” said Michael Barnett, 69, of San Francisco. Studies have differed on whether virtual health care actually saves insurance companies money. Telemedicine requires its own infrastructure, plus resources and training to support it, which can be costly for health plans.

Barnett hasn’t used telemedicine, skeptical of the “one-off” kind of encounter he thinks it amounts to. He prefers a doctor’s personal touch. “Your physician should know your history,” he said. “In telemedicine, you’re probably getting someone who doesn’t know much about you. They may have access to it electronically, but it’s likely to be very skimpy.”

In the right setting, there’s nothing wrong with telemedicine per se, said Anthony Wright, executive director of Health Access California, a statewide consumer advocacy coalition.

But many people — whether it’s a cancer patient receiving chemotherapy or a child with a broken arm — will need hands-on care, he said.

Wright said advocates fought hard for laws in California requiring health plans to provide consumers with timely access to treatment. “We want to safeguard those protections,” he said. “We don’t see telemedicine as replacing the need for those standards.”