Medscape

Should You Join a Virtual Physician Network?

Neil Chesanow

September 24, 2014

The Debate Heats Up Over Virtual Visits

Remote patient visits via videoconferencing and other telehealth tools, such as telephone, secure email, and texting, are growing faster than physician organizations and state and federal regulators can keep up with and control them.

In August, Deloitte predicted that out of an average 600 million general practitioner appointments in the United States and Canada in 2014, up to 75 million could be electronic visits, including videoconferencing and remote consultations by telephone, texting, and secure email.[1]

That same month, research by Parks Associates forecast that patient visits via videoconferencing alone, the fastest-growing mode of telehealth, are about to triple -- from 5.7 million in 2014 to over 16 million in 2015, and will skyrocket to over 130 million in 2018.[2] Other surveys also forecast dramatic growth.[3,4]

Be that as it may, many patients who could benefit from virtual visits with physicians -- among them those who have uncontrolled chronic conditions, such as diabetes; who have homebound illnesses, from parkinsonism to depression; who are elderly and too fragile to travel; who lack social support; or who live in underserved areas -- still can't see a doctor without leaving home.

Lack of remote access to a physician may be due to state regulations governing which doctors can see which patients using which telehealth technologies for a virtual visit, or, in the case of Medicare patients, it may be due to limitations imposed by the Centers for Medicare & Medicaid Services (CMS).

Even if everyone who wanted to interact with a doctor remotely could do so, whether there will be enough physicians to meet the demand remains an open question, because some restrictions currently limit physician participation in virtual visits.

Not your problem? Don't be too sure. If you are contemplating quitting medicine -- not because you don't love it, but because you crave a normal life -- seeing some or even all of your patients online can enable you to cut down on office hours, work from home at your own pace, set your own schedule, and care for patients in a way that more and more of them are telling surveyors they want.

Conversely, if your practice isn't busy enough and you seek to increase revenue by seeing more patients, who are proving difficult to attract locally, offering virtual visits can significantly augment your income -- provided, of course, that you can see enough of them online to make it worth your while.

What are the restrictions limiting what many doctors and patients want? Are they legitimate? Should they be relaxed or rescinded? Let's take a look.

Does a New Streamlining Initiative Go Far Enough?

Seeing patients on the Internet isn't distance-dependent. Would a physician in, say, Pennsylvania, interacting with a patient for, say, a urinary tract infection, on a smartphone or tablet treat a patient with the same condition any differently if that patient were living in any other state?

Right now, the issue is academic. Physicians conducting remote visits must be licensed in each state in which a patient being treated resides, no matter how routine the patient's condition.

"We have 50 different state fiefdoms with huge borders that have been erected around them that are primarily intended so that out-of-state doctors can't come in and compete against local doctors," contends Jonathan Linkous, CEO of the American Telemedicine Association.

Linkous says that 50 variations in the licensing of physicians is costing taxpayers approximately $300 million a year "and will probably double or triple very soon."

The welter of differing state fees and licensing requirements creates formidable challenges for doctors who seek multiple state licenses, limiting the pool of those available for providing videoconferencing and other telehealth services remotely.

According to internist Humayun Chaudhry, DO, CEO of the Federation of State Medical Boards (FSMB), 94% of physicians licensed to practice medicine in the United States are licensed in only one state.

In April, FSMB proposed an "interstate compact" that would make it easier for doctors to apply for multiple licenses by permitting them to send all the documentation required by each state to a central location -- an "interstate commission" -- that would lop months of bureaucratic delay off the application approval process, Dr. Chaudhry explains.

However, critics charge, this wouldn't reduce the daunting documentation requirements for physician licensure by each state.[5-8] Nor would it reduce the licensing fees that each state charges doctors, which can total thousands of dollars if multiple state licenses are sought.

What's needed is a state licensing reciprocity agreement, as is the case with drivers' licenses, Linkous believes. This isn't it.

"The federation is taking a step" in making virtual visits easier for physicians to offer, Linkous recently told Medscape. "But it's a baby step, and what we need is a giant step."[6]

The Supply-and-Demand Paradox

Despite soaring demand for virtual visits, and restrictions on the doctor supply, it isn't clear that there's an insufficient number of physicians to see everyone who wants to be seen online.

California, for example, has 38 million residents.[9] The Parks Associates survey found that nearly 50% of households with broadband access in the state already use an online health service from a physician.[10]

There may be a shortage of California doctors in brick-and-mortar practices, but there doesn't seem to be a shortage of doctors to see California patients online.

Major virtual physician networks seem to be meeting the demand just fine as well. The Newbury Park, California-based Online Care Group, with such insurers as United Healthcare and WellPoint among its clients, has 30 full-time physicians and 200-300 moonlighting physicians seeing patients virtually in 47 states.

Yet despite its volume of virtual visits growing at a rate of 30% per month, the group isn't seeking more physicians at the moment, except in selected cases, says pediatrician Peter Antall, MD, President and Medical Director. The network already has a backlog of some 300 physicians waiting to join, he says.

Sunshine, Florida-based MDLIVE, whose clients include the insurer Cigna, as well as hundreds of self-insured employers and hospitals, has seen its user base grow from over 3.5 million patients in January to about 4.5 million patients in August, says CEO Randy Parker. Yet the number of physicians who see these patients on its virtual network has remained the same: about 2000 doctors, most of whom work part-time.

How can this be? The answer is in logistics. Virtual visits commonly last about 10 minutes, and in states with high demand, patients queue up, so there's no lag time between visits. As such, a doctor can see more patients remotely in an hour than he or she could in the office. The more efficient each doctor can be online, the fewer doctors who are needed, even as patient demand continues to grow.

WellPoint, which began offering virtual patient visits last year, now makes them available to health plan members in 44 states, but the insurer has enough physicians to conduct them, at least for the time being, says John Jesser, MBA, Vice President of Patient Engagement Strategy.

"You can cover 44 states 24/7 with a relatively few doctors with multiple state licenses," Jesser observes. "We have worked with medical groups to create staffing to cover our needs. As demand grows, we will add to that. But part of the challenge is that there may be more doctors interested in doing this right now than there really is demand."

Does this mean online opportunities for physicians are all taken? On the contrary, the major networks may not be hiring at the moment, although that may soon change. Meanwhile, though, smaller state, regional, and fledgling national networks of telehealth providers are springing up across the country, often backed by millions of dollars in venture capital, and many of them are actively recruiting physicians.

Moreover, many physician groups are establishing -- and marketing -- virtual "storefronts" on preexisting telehealth networks to see their own patients and expand their panels, notes internist Roy Schoenberg, MD, MPH, CEO of American Well, a national telehealth provider in Boston, Massachusetts, that hosts a growing number of these branded storefronts. Because these mini-networks within larger networks are set up see their own patients, and

are otherwise independent, they aren't constrained by the larger network's physician staffing needs -- or lack of them.

Not only are these online presences being established by independent practices, they are also being established by accountable care organizations (ACOs) and patient-centered medical homes (PCMHs), especially those that take full risk, Dr. Schoenberg says. Having 10-minute virtual visits with, say, a noncompliant diabetic patient, makes regular monitoring feasible; seeing that patient every six months in the office, because that's all your busy schedule can accommodate, isn't good for the patient or your bottom line.

New Standards and Safeguards From the AMA

Shortly after FSMB proposed its interstate compact, the American Medical Association (AMA) issued a policy statement saying that although a "face-to-face relationship" was the preferred mode of physician/patient interaction, virtual visits that included both video and audio interaction were, in some cases, an acceptable substitute.[11] However, absent an initial visit in person or by videoconferencing, virtual consultations with patients by other telehealth means -- phone, secure email, or texting -- weren't endorsed.

The AMA, in concurrence with FSMB, reiterated that physicians offering virtual patient visits should be licensed in the states in which those patients reside.[6]

Critics view the AMA's policy as an obstacle to democratizing healthcare that telehealth represents.[12,13] By excluding telephone, secure email, and texting consultations from sanctioned telehealth options, they say, many patients who don't have an established face-to-face relationship with a primary care physician, can't afford a home computer, or live in an underserved area are shut out of the telehealth market when a remote visit with a physician is their only realistic option.

The Deloitte study notes that telehealth and videoconferencing are often perceived as being synonymous. Not so. "The vast majority of eVisits are likely to be more functional and focus on capturing patient information through forms, questionnaires and photos, rather than through direct interaction with a physician," the authors write.[14]

"We felt that it was important with this new technology that we as physicians put down some guidelines for how best use it to improve the care of our patients," counters reproductive endocrinologist Robert M. Wah, MD, the AMA President, in explaining why videoconferencing was the only telehealth technology endorsed by the association, and why a universal license for physicians conducting virtual visits was not a good idea.

Advocates of state licensing reciprocity for virtual patient visits contend that the FSMB's and AMA's insistence that doctors be licensed in states where patients reside is an unnecessary obstacle to sorely needed telehealth expansion.[12,13] They cite as a precedent the Servicemembers' Telemedicine and E-Health Portability (STEP) Act of 2011, which allows military doctors licensed in one state to see members of the armed forces anywhere in the United States.[15]

Dr. Wah, who served for over 23 years on active duty as a captain in the US Army Medical Corps, views this as an apples-and-oranges comparison.

"The Department of Defense (DOD) has a system of care where all their patients are taken care of in one system-wide network," he observes. "They have other mechanisms by which they can monitor and maintain compliance to DOD regulations across the enterprise. They don't need to use individual mechanisms, like the states do."

Dr. Wah says state licensure "provides a monitoring and enforcement system to try to ensure that we minimize when less-than-perfect care is delivered."

He adds, "The Department of Defense, big as it is, takes care of 10 million patients worldwide. There are 330 million patients in the United States. So there's more chance for variation across that population than there is in the DOD's."

Moreover, states legitimately differ in how healthcare is delivered that should be respected, such as the treatment of minors, Dr. Wah insists. "How a minor gets treated, and how parents get notified of that treatment, are nonmedical issues, but they're very important in terms of patients, their families, and how such treatment intersects with the healthcare delivered in a given state," he says.

Will Congress Vote to Facilitate Virtual Visits?

In recognition of the potential of telehealth to make healthcare more accessible and affordable to many patients, several bills have recently been introduced in the House of Representatives that, if passed, would make it easier for you to offer telehealth visits, especially video visits, to more patients. For example:

Telehealth Modernization Act of 2013. Does telehealth include only videoconferencing, or does it also include doctor/patient communication using other remote technologies, such as telephone, email, and texting? That depends on which state you're in. The Telehealth

Modernization Act aims to clear up the confusion by establishing a federal definition of telehealth that would be universally applicable.[16]

The bill, introduced in the House in December, is based on California legislation, which would add "store-and-forward" technology -- including video clips, still images, radiographs, MRIs, ECGs, EEGs, lab results, and audio clips -- sent as secure email attachments. Right now, most states permit only video visits.[16]

TELE-MED Act of 2013. CMS currently pays for some videoconferencing services to Medicare patients -- including provider consultations and office visits -- but only in an "originating site," such as a doctor's office, hospital, or rural health clinic, not in a patient's home, and only if the provider is licensed in the state where the patient resides. This act, introduced in the House in September 2013, would let providers treat Medicare beneficiaries via virtual visits across state lines, without having to obtain multiple state licenses.[17]

21st Century Care for Military and Veterans Act. Introduced in the House in November 2013, this bill would establish and expand the use of telehealth services under TRICARE, the DOD health program, to active-duty service members and their dependents, retirees, and veterans, many of whom live in rural and underserved communities and lack access to a primary doctor.[18]

Medicare Telehealth Parity Act of 2014. This bill, introduced in the House in July, would allow for the incremental expansion of telehealth services covered under Medicare over a four-year period.[19] That same month, CMS proposed expanding such services to include annual wellness visits, psychotherapy and psychoanalysis (behavioral health issues are the number-one reason for virtual visits), and prolonged evaluation and management services to its Physician Fee Schedule for 2015.[20,21]

Six months after the bill's passage (assuming, of course, that it *is* passed), telehealth services would be expanded from rural and underserved areas to urban areas with a population of at least 50,000.[20,21] Retail clinics -- such as those that a growing number of retail pharmacies, retail stores, and employers (most notably Walmart) now offer -- would be approved sites.[22]

After two years, urban areas with a population of 50,000-100,000 would be covered under the Physician Fee Schedule, and reimbursable telehealth outpatient services would be expanded to include speech and physical therapy.[20,21] Also covered would be remote home

monitoring of patients with chronic obstructive pulmonary disease, congestive heart failure, and diabetes.

Do such bills mean that lawmakers are embracing the unrestricted availability of virtual visits? That conclusion would be unrealistically optimistic. According to predictions by GovTrack.us, which tracks bills in Congress, the Medicare Telehealth Parity Act, to take one example, has a 0% chance of being enacted,[23] and the 21st Century Care for Military and Veterans Act has a 1% chance.[24]

Similarly, by universalizing which technologies can be used -- and reimbursed for -- in virtual visits, the Telehealth Promotion Act would have the federal government, in essence, preempt states' rights on this issue. The chances of that being passed in the Republican-dominated House are remote.

A Mixed Prognosis for Virtual Visits

Right now, the spread of telehealth is moving along two uneven tracks. Health plans, employers, hospitals, integrated delivery systems, ACOs, PCMHs, and forward-thinking physician groups are rapidly adopting virtual visits -- and other tools for remotely seeing and monitoring patients -- as an essential component of a population-based healthcare system called for by the Affordable Care Act.

Meanwhile, organized medicine, the states, CMS, and Congress are moving at a much slower and more cautious -- some would say inhibitive -- pace.

"This technology has exceeded our ability to understand, regulate, and pay for it," says Jonathan Linkous. "We need a new paradigm for delivering healthcare. Once you can use an ATM, why would you go back to the old style of banking? Patients are starting to demand this. People have sued hospitals because they didn't use telemedicine. The claim was that this is now the standard of care."