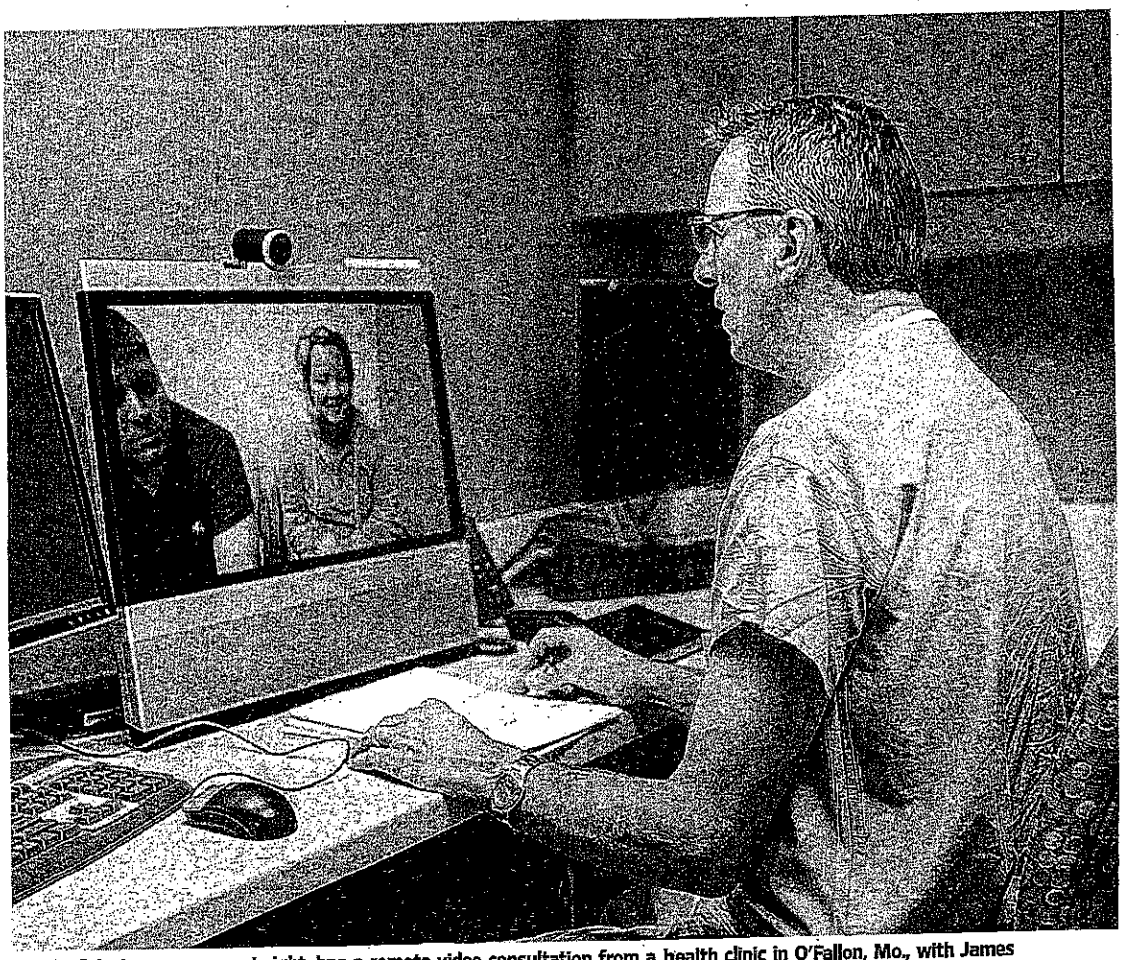
The Specialist Will See You Now, on V

By Laura Landro



Jessica Prinster, on screen at right, has a remote video consultation from a health clinic in O'Fallon, Mo., with James Bartelsmeyer, director of the Maternal and Fetal Health Center at Mercy Hospital St. Louis, seated at desk.

Suffering from severe, constant migraines, Vickie Stroot, 39, had trouble finding treatment near her home in Rolla, Mo.,

But thanks to a video connection between a local clinic and an urban hospital both owned by Mercy, the big Catholic health system, Ms. Stroot has regular virtual appointments with a specialist at the Mercy Clinic Headache Center without making the 100-mile trip to St. Louis.

Even in some major population centers, medical specialists are in short supply in fields including high-risk pregnancy, behavioral health and neurology. A shortage of nearly 65,000 nonprimary-care specialists is projected by 2025, the Association of American Medical Colleges says.

Big health-care systems, where most specialists work, are turning to interactive video consultations to give patients high-quality ongoing care for complex problems without requiring them to travel long distances or wait months for an appointment.

Mercy, with 42 acute-care and specialty hospitals, 700 clinic and outpatient facilities and more than 2,100 doctors in four states, is breaking ground this week on a $50 million virtual-care center. When it opens next year it will house 75 telemedicine programs staffed by 300 medical professionals linked to Mercy facilities and partner hospitals.

More than half of U.S. hospitals now use some form of remote technology to deliver clinical services, according to the American Telemedicine Association, which says there are some 200 telemedicine networks currently serving 3,500 facilities.

Networks have often focused on helping doctors consult with one another or seek expert help on issues such as stroke care. At remote "eICU" central command stations, with two-way video and audio systems, intensive-care professionals oversee multiple intensive-care units. Mercy has one of the nation's biggest eICU programs, covering more than 450 beds in 28 ICUs.

Medical centers are using some of the same technology for one-on-one doctor-patient consultations. Using "store and forward" technology, remote specialists can view electronic images such as X-rays, MRIs and digital photos of the skin. With live streaming video they can view images from, say, an inner ear scope.

The federal Medicare program has been steadily expanding coverage of telemedicine services. About 20 states require private insurers to cover remote consultations the same way they cover in-person services. The Federation of State Medical Boards last month issued voluntary telemedicine guidelines for its 70 member boards. The guidelines suggest using video technology rather than audio or email technology for the first telemedicine encounter with a patient. fostering patient-doctor relationships and following strict guidelines for privacy, security, informed consent and safe prescribing.

Big hospitals are using interactive video to give more patients access to ongoing specialized care for complex problems.

The Veterans Health Administration, which offers clinical video consults in 45 specialties at more than 800 sites, says 11% of veterans received elements of health care including PTSD therapy remotely last year, which helped reduce costs and improve patient satisfaction.

Currently, to have a virtual visit with a Mercy specialist, patients typically go to a nearby clinic operated by Mercy or another provider. A limited number of consults are available on mobile devices and more will be offered in future. "We plan to expand telemedicine on every front," says Lynn Britton, Mercy Health president and chief executive. "Not only have we seen it improve patient access and outcomes, and reduce readmissions and costs—our patients are demanding it."

Next year, Mercy plans to extend video consults to primary-care physicians. Unlike patients at many for-profit services offering virtual-doctor visits, telemedicine patients must have an ongoing relationship with a Mercy doctor.

Mercy's Mr. Britton says with video consultations, both patients and doctors report that "all the distractions fall away, and it's a one-on-one, focused experience."

Timothy R. Smith, the Mercy headache specialist who sees Ms. Stroot, spends Tuesday afternoon in a dedicated telemedicine room. Nurses at outlying local clinics use a scope to look inside the patient's ears, and Dr. Smith sees the results on a streaming video feed.

Ms. Stroot has had brain scans that ruled out potential causes such as a tumor. Her ongoing consultations help monitor medications and lifestyle issues, such as diet. During recent appointment, she and Dr. Smith discussed how high blood

alist Will See You Now, on Video

pressure might trigger headaches, and he prescribed medication.

"Most of the diagnosis and management of headache is asking the right questions and listening," Dr. Smith says. "That can be done on two-way video without any sort of compromise." While it is always ideal to see patients in person, he adds, "a telemedicine encounter is better than no consultation capability at all."

Jessica Prinster, in her third month of pregnancy and at risk of complications because of several back surgeries, had an ultrasound at a Mercy health clinic in O'Fallon, Mo. She got the good news that everything was normal in a videoconference with James Bartelsmeyer, director of the Maternal and Fetal Health Center at Mercy Hospital St. Louis.

To see him in person, Ms. Prinster, who has two children at home, would have had to wait at least a week for an appointment and arrange a long car trip and extra pay for her babysitter. Instead, she and her boyfriend had the video consult in a private room at the clinic.

Dr. Bartelsmeyer does virtual consults with patients at three sites within 40 miles of the hospital. He acknowledges there can be shortcomings. "It's hard enough to give bad news and sometimes doing it over a webcam is not ideal," he says. "A lot of times I apologize and say I prefer not to give you this news this way."

Video consults are used for behavioral therapy, too. Nita Mihlfeld has cared for 14 foster children over several years. She and her husband have missed work and kept those children who needed psychiatric care out of school to travel two hours to Springfield to see a Mercy child and adolescent psychiatrist, Kyle John.

For the past two years, Ms. Mihlfeld has brought several of the children to a Mercy clinic 10 minutes from her home to see Dr. John via video. Each child gets 20 to 40 minutes, and everyone is done by midmorning. The children enjoy the video sessions and open up easily with the doctor, Ms. Mihlfeld says.

With younger children, Dr. John can observe as they are examined by a pediatrician or nurse. He looks for traits such as aggression when they play with toys and zooms in to see if they have tics or tremors.

He tells families they are always welcome to make the drive to see him. But in two years, he says, "not a single one has decided it's necessary to do that."

Patients and economy would benefit from KanCare expansion

by Gene Meyer

As many in our community are aware, the U.S. Supreme Court ruled when they reviewed the Affordable Care Act that states could not be required to expand their Medicaid eligibility. As a result, to date, Kansas has declined to expand Medicaid eligibility for low-income residents. Current income limits for eligibility for KanCare, which is the name for the state's Medicaid program, are among the worst in the country, and about one in seven Kansas adults under 65 remains uninsured.

The Kansas Hospital Association estimates that expanding KanCare could enable 169,000 low-income Kansas adults to gain coverage, nearly half of the state's 369,000 uninsured. Based on U.S. Census Bureau estimates, there are at least 9,000 people in Douglas County below the eligibility criteria for expanded Medicaid. This is significant.

Making a decision on expansion of KanCare is first and foremost about coverage for those individuals. But it's also about costs and the economy.

The cost of caring for those who would be covered by KanCare expansion is already being absorbed by hospitals, health care providers, businesses and other payers. Lack of insurance keeps people from receiving regular care. Unfortunately, these individuals often resort to using our emergency rooms because their health is not properly managed. Uncompensated care ultimately touches all of us because it increases the cost of health care, and a portion of those costs are passed along to those who have insurance in the form of higher premiums.

Millions of dollars are leaving Kansas, going to the federal government, and then going out to states that have decided to expand Medicaid. Kansas hospitals, as well as 72 percent of Kansans (according to a recent poll by the American Cancer Society) would like to see Kansas money come back to Kansas to cover more of the uninsured, and not go to states like California, Colorado and Ohio.

According to the Kansas Hospital Association, Kansas is losing approximately $334 million in federal funding in 2014 and more than $380 million in 2015, compared to the amounts it would have earned had it expanded KanCare. The association has issued a report, *Economic and Employment Effects of Expanding KanCare*, conducted by the Center for Health Policy Research at George Washington University, which quantifies the negative consequences of the state's decision to not expand KanCare in 2014. The report also highlights the positive benefits implementation of KanCare expansion by 2016 could have for Kansas taxpayers and businesses, as well as uninsured citizens. This independent analysis provides solid data to help Kansas decide whether to accept or decline some $2.2 billion in federal funds between 2016 and 2020.

The study indicates that not expanding KanCare is already hindering job creation and economic growth because Kansas is not capturing hundreds of millions in federal matching dollars that would otherwise flow into the state economy to make expansions more affordable. The research concluded that expansion would have created more than 3,000 jobs statewide in 2014 and beyond.

The report clearly demonstrates the economic benefits of KanCare expansion. About half of the jobs created would be in health care, but the other half would be in diverse sectors, including construction; retail and wholesale; professional, scientific and technical; and food and beverage. Although KanCare expansion increases funding for health care, the benefits spread broadly as health care providers purchase additional goods and services and use their income to pay their mortgages, buy groceries and make consumer purchases that broadly impact the state's economy.

The report further goes on to say that over the five-year 2016 to 2020 period, KanCare expansion would increase the state gross product by more than $1.2 billion and total business activity by about $2.2 billion. Expanding KanCare would trigger additional economic growth for Kansas, leading to greater state tax revenues without changing tax rates. Failure to expand KanCare will derail substantial economic gains that could boost the state's economy and forego more than $69 million in potential state revenue that could be used to help balance state budget.

The bottom line for many is cost, and this report demonstrates that KanCare expansion produces a net savings to the state. If the state expands KanCare by 2016, there are increased state Medicaid costs, but those are offset by new state revenue and reductions in other health care spending. The net savings to Kansas would total $29 million in 2016 and approximately $36 million from 2016 to 2020, according to the financial analysis in the report. The full report and a summary brief can be found on the KHA website at www.kha-net.org.

A decision to forego KanCare expansion is more than just a decision to refuse the federal funding associated with Medicaid expansion. In fact, it amounts to real cuts to hospitals like Lawrence Memorial that are currently serving as the primary safety net for many uninsured individuals, and it comes at a time when the uncompensated care burden continues to grow at an alarming rate. In 2014 it is estimated that LMH will write off about $15 million in charity care alone and that number is projected to grow to about $16 million next year.

I and many of my peers at Kansas hospitals believe that Kansas should thoughtfully develop a unique, Kansas-based solution that takes advantage of the federal funds to build upon and improve our current KanCare program. To do this will require the Kansas Legislature and governor to address this critical social and economic issue in a reasonable way. We read of the deficit our state has that could be offset by the positive economic impact KanCare expansion would have. It is imperative that our legislators act on this in the upcoming legislative session.

If you have questions or thoughts on this, I welcome your call. My direct number is 785.505-6130 and my e-mail is gene.meyer@lmh.org. Thank you.

Gene Meyer is President and Chief Executive Officer of Lawrence Memorial Hospital.

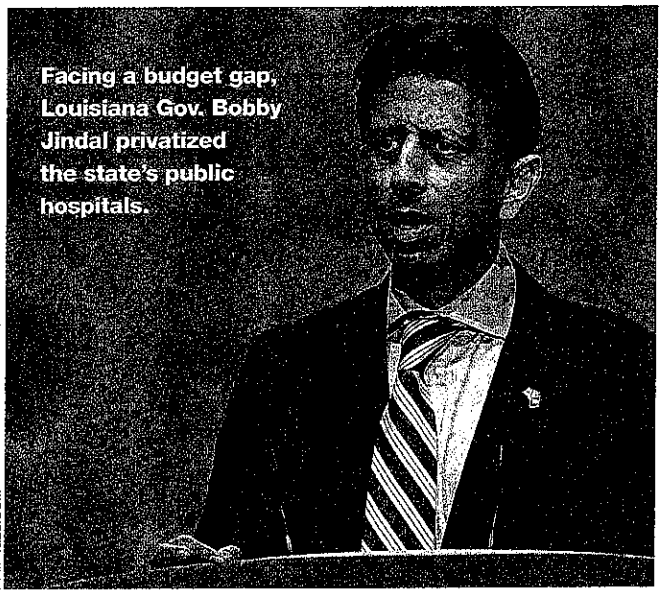
By Chris Kardish

Why Rejecting Medicaid Isn't Easy

The need to fund safety-net hospitals puts expansion on the table in some states.

Louisiana—with its parishes, its Continental system of laws and its Cajun-inflected way of life—has always been unique among American states. But there's another distinction that makes Louisiana different: It's the only state that has for centuries maintained a network of public teaching hospitals to treat the poor and uninsured.

Now that system could be in trouble, thanks to recent state decisions and federal changes to the way safety-net hospitals are funded. As a result, Louisiana officials must figure out if they can maintain their safety net and still refuse federal Medicaid money.



Facing a budget gap, Louisiana Gov. Bobby Jindal privatized the state's public hospitals.

AP/IMAGES.COM

It's a challenge the 22 other states that haven't expanded Medicaid will likely encounter in the coming years.

Faced with a major budget gap in 2012, Gov. Bobby Jindal moved to privatize nearly all 10 of the state-run hospitals, which receive most of their funding from the federal government through the Disportionate Share Hospital (DSH) program. Today, more than a year into the experiment, the plan has certainly seen some clear successes. Patient wait times, for instance, have dropped dramatically. But the change has led to some unanticipated consequences as well. Privatization resulted in the closure of two hospitals, and instead of heading to any of the other now public-private facilities for care, uninsured patients started visiting private "nonpartner" facilities that don't receive any DSH compensation.

The problem is that Louisiana's pool of DSH funding goes almost exclusively to the now public-private hospitals. That's causing short-term headaches as more nonpartner private hospitals take on indigent patients who previously went to now-shuttered public facilities. In one case, a hospital nearly closed its emergency room until the state offered $18 million in aid. But the long-term situation is what most worries critics in Louisiana and across the U.S.

The DSH program is scheduled for $18 billion in long-term cuts beginning in 2016. Federal lawmakers decided to phase out the program after Congress passed the Affordable Care Act; with more low-income patients covered by Medicaid, they figured, the DSH program would no longer be needed. But when the Supreme Court ruled that states can't be required to expand Medicaid, the problem became much more complicated.

Some critics wonder how Louisiana—with the threat of future cuts and a budget deficit that could top $1 billion—could possibly maintain its system without embracing at least some form of expanded Medicaid.

Louisiana's problem may be uniquely tough because DSH funding is concentrated among a few places and the state receives a whole lot of it because so many people are uninsured. But safety-net hospitals in other states face similar problems, especially in the absence of Medicaid expansion. In Georgia, for example, Elbert County is considering a tax increase to keep its safety-net hospitals alive. In Wyoming, state analyses of potential budget savings and complaints from hospitals of losing $200 million a year in uncompensated care are moving officials in the direction of expansion.

Louisiana officials argue immediate fears are overblown. Jeff Reynolds, undersecretary for the Louisiana Department of Health and Hospitals, says the surge of uncompensated care in nonpartner hospitals seems to be receding as patients adjust to the new system. Although the state is exploring more permanent solutions for private hospitals that are still serving a large number of uninsured patients, the impact of DSH cuts is expected to be low in the early years, Reynolds says, because reductions will reflect the number of uninsured patients that remain in each state.

Still, by 2020 total DSH spending will have fallen to half its historical level, dealing a major blow to any state that's dependent on that money. In fact, cuts to DSH spending will add up to a $350 million shortfall between 2018 and 2020, according to the Public Affairs Research Council, a nonpartisan think tank based in Baton Rouge.

There are signs officials in Louisiana, at least, are recognizing that. The top two Republicans vying to replace Jindal have both said they'd accept Medicaid expansion with some conditions. **G**

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