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## Memo

**Date:** August 30, 2016

**To:** Senator Krebsbach, Chair  
 Legislative Employee Benefits Programs Committee

**From:** Josh Johnson and Pat Pechacek, Deloitte Consulting LLP

**Subject:** REVIEW OF PROPOSED BILL 17.0120.01000 RELATING TO INSURANCE COVERAGE OF TELEHEALTH SERVICES

The following summarizes our review of the proposed bill.

### OVERVIEW OF PROPOSED BILL

As proposed, this bill would require the medical benefits coverage of services provided by a health care provider by means of telehealth which are the same as medical benefits coverage for the same services provided by a health care provider in-person. There is widespread support for health plan coverage and incentivizing expanded use for telehealth services.

### Telehealth – Deloitte Health Policy Brief

Attached is a copy of a recent health policy brief from Deloitte titled: Realizing the potential of telehealth". The executive summary of that report states:

*Improving digital connectivity between patients and providers is critical to achieving value-based, patient-centered care.*

*Many health care organizations are exploring strategies to leverage technology, including telehealth, to increase consumer engagement and focus on prevention and chronic care management outside the traditional physician office visit. Findings from Deloitte's 2016 Survey of US Health Care Consumers shows that interest in and use of telehealth is rising. The policy landscape—including payment policy and care provisions across state lines—is evolving to keep up with consumer demand and technology innovations.*

*An aging population, increasing chronic illness, the importance of self-care, accelerating health costs, regulatory reform, and new payment models are driving interest and growth in telehealth.<sup>1</sup> Some recent studies show that*



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*telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,<sup>2</sup> while others are concerned about its potential to increase costs in a fee-for-service environment.<sup>3</sup> Under new value-based payment models that reward outcomes (including lower total cost of care) rather than utilization, telehealth may be a cost-effective solution to provide access to care and, ideally, reduce unnecessary hospital care. Given these trends, providers and health plans should continue to monitor the complex and ever-evolving policy landscape around telehealth, and consider adopting targeted strategies for telehealth that encourage self-care and increase medication adherence to realize the clinical and economic benefits.<sup>4</sup>*

*New telehealth policies will likely need to balance potential increased access to services with potential cost increases, as well as payment and licensing changes and what they may mean for provider business models.<sup>5</sup> This policy brief provides an overview of trends in telehealth and consumer interest; the regulatory landscape; and the potential barriers, opportunities, and enablers for telehealth in the coming years. Top-of-mind policies for providers and health plans include:*

- *Current Medicare payment policy and proposed legislation to change it*
- *The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its impact on telehealth*
- *Centers for Medicare and Medicaid Services (CMS) initiatives that are encouraging telehealth*
- *Recent Medicaid legislation that encourages telehealth<sup>6</sup> in states and Medicaid managed care*
- *State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations*

## **CURRENT SCOPE OF COVERAGE IN NDPERS**

Currently, NDPERS covers health services that are delivered by telehealth in the same manner as health services provided in-person. The payment/reimbursement of telehealth services is established through negotiations with health care providers conducted by Sanford Health Plan as NDPERS' contractor. The NDPERS bill, as it stands today, does not cover telehealth services that are not medically necessary or if the policy would not provide coverage if the health services or expenses for health services were provided by in-person means. The NDPERS telehealth bill also does not require a health care provider (like a nurse or doctor) to be physically present with a patient at the originating site unless the health care provider who is delivering health services via telehealth determines that the presence of a health care provider is necessary. NDPERS Telehealth Summary Experience.

Female infertility, behavioral health and sleep apnea were the top three diagnoses for the first year of this program. Telehealth has enabled patients in the rural and outlying areas of the state to continue to see their specialist residing in one of the state's four major

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cities without having to travel hundreds of miles. Additionally, telehealth has been a means to address the shortage of behavioral health providers in rural areas and has enabled rural members access to behavioral health services.

## **TECHNOLOGY**

There are many different ways in which telehealth can be provided:

- Online, two-way video using a personal computer
- Smart phone
- Other online monitoring systems such as remote cardiac monitoring

The types of telehealth technologies will likely increase over the coming years as telehealth vendors increase. Between 2014 and 2015, the number of vendors selling telehealth technologies increased 23%.

## **NDPERS EXPERIENCE**

Attached is summary of the NDPERS Telehealth Experience prepared by Sanford. You will note in the attached:

- From July 1, 2015 to June 30, 2016 there were 1022 total telehealth claims. telehealth visit and the originating site charge.
- 551 of these claims refer to the professional service, totaling \$63,040.
- 387 of these claims refer to the originating site charge.
- The originating site charge includes being checked in by a nurse and the use of a secure video connection between the member and Physician.
- 74.4% of telehealth claims were between a provider and member/resident who were both in the state of North Dakota
- 8.4% of the telehealth claims were between an ND resident and a MN provider
- 85% of total claims came from 10 types of specialists
- Top 10 Provider Specialties:
  - 1. Reproductive Endocrinology (OB/GYN)- 341 claims
  - 2. Psychiatry- 211 claims
  - 3. Child & Adolescent Psychiatry- 71 claims
  - 4. Psychology- 75 claims
  - 5. Nurse Practitioner (OB/GYN)- 32 claims
  - 6. Sleep Medicine- 26 claims
  - 7. Family Medicine- 19 claims
  - 8. Internal Medicine- 46 claims
  - 9. Clinical Nurse Specialist (Psychiatric/Mental Health)- 27 claims
  - 10. Nurse Practitioner- 26 claims

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## Savings

As noted in a recent memo from Sanford Health Plan there is the possibility of savings not only for NDPERS members, but also NDPERS as a payor:

- In a 3 year study of high-risk dialysis patients, the patient group that was monitored via remote technology had a significantly lower amount of hospitalizations and hospital days, along with significantly lower hospital and emergency room charges<sup>1</sup>.
- A study of Medicare members who were monitored after discharge from the hospital found a 44% reduction in 30-day readmissions amongst members who were monitored versus the control group<sup>2</sup>.
- Heart failure patients participating in a telemonitoring study had 12% lower total costs<sup>3</sup>.
- A study of a 15-hospital, rural, multi-state ICU telemedicine program found a 37.5% reduction in the number of patients requiring transfer via ambulance or helicopter services. In total, there were 6825 fewer days spent in the ICU by patients, along with 821 fewer hospital days. The reduction in ICU days saved approximately \$8 million, and an additional \$1.25 million saved due to reductions in length of stay<sup>4</sup>.
- A peer-reviewed study in Critical Care Medicine found that continuous, contact-free patient monitoring has the potential to save the US healthcare system up to \$15 billion annually<sup>5</sup>.

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<sup>1</sup> Dayna E. Minatodani & Steven J. Berman, *Home Telehealth in High-Risk Dialysis Patients: A 3-Year Study*, 19 TELEMEDICINE AND E-HEALTH 520–522, 520-522 (2013).

<sup>2</sup> Jove Graham et al., *Post discharge Monitoring Using Interactive Voice Response System Reduces 30-Day Readmission Rates in a Case-managed Medicare Population*, 50 MEDICAL CARE 50–57, 50-57 (2012), [http://journals.lww.com/lww-medicalcare/abstract/2012/01000/postdischarge\\_monitoring\\_using\\_interactive\\_voice.7.aspx](http://journals.lww.com/lww-medicalcare/abstract/2012/01000/postdischarge_monitoring_using_interactive_voice.7.aspx).

<sup>3</sup> Christopher Tompkins & John Orwat, *A Randomized Trial of Telemonitoring Heart Failure Patients*, 55 JOURNAL OF HEALTHCARE MANAGEMENT 312–322, 312-322 (2010), <http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=af518a72-40b4-425a-95d2-4cb652ac97d4@sessionmgr4009&vid=0&hid=4107> (last visited Aug 16, 2016).

<sup>4</sup> Edward Zawada, Patricia Herr & Deanna Larson, *Impact of an Intensive Care Unit Telemedicine Program on a Rural Health Care System*, 121 HEALTH ECONOMICS 159–170, 159-170 (2009), [https://www.researchgate.net/profile/edward\\_zawada/publication/26262120\\_impact\\_of\\_an\\_intensive\\_care\\_unit\\_telemedicine\\_program\\_on\\_a\\_rural\\_health\\_care\\_system/links/54b98c080cf2d11571a4b58c.pdf](https://www.researchgate.net/profile/edward_zawada/publication/26262120_impact_of_an_intensive_care_unit_telemedicine_program_on_a_rural_health_care_system/links/54b98c080cf2d11571a4b58c.pdf).

<sup>5</sup> Fred Pennic, *STUDY: CONTINUOUS PATIENT MONITORING COULD SAVE HEALTHCARE \$15B* (2016), <http://hitconsultant.net/2016/08/08/study-continuous-patient-monitoring-healthcare/> (last visited Aug 16, 2016).

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## **OBSERVATIONS AND RECOMMENDATION**

A recent health policy brief released by the Deloitte Center for Health Solutions titled *Realizing the potential of telehealth: Federal and state policy is evolving support telehealth in value-based care models*, supports the position that telehealth has the potential to reduce treatment costs and improve patient access to care. As stated in the policy brief:

*"Telehealth aims to make health care services more accessible to patients so that they can avoid going to the physician's office. Instead, patients can access care any time, via different devices—a web browser, a mobile phone or tablet, or a standalone kiosk in a retail clinic. Telehealth has the potential to improve remote monitoring and self-care strategies and, ultimately, reduce treatment costs by keeping people out of the hospital and emergency room, and reducing physician office visits."*

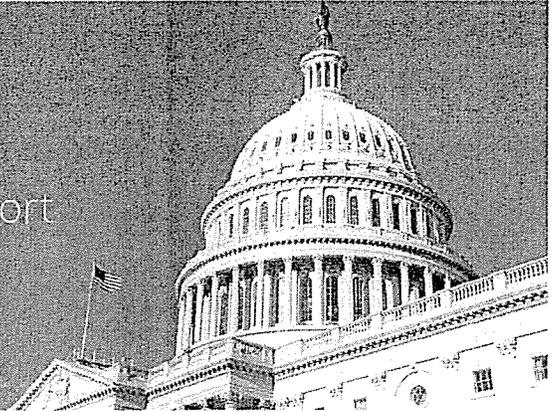
From reduced restrictions on telehealth through Accountable Care Organizations (ACO's) by the Centers for Medicare and Medicaid Services (CMS) to studies conducted by organizations such as the Agency for Healthcare Research and Quality (AHRQ), the support for expansion of and removal of traditional barriers for coverage of telehealth are prevalent. A recent technical brief from the AHRQ notes that there is sufficient evidence to support the effectiveness of telehealth, including remote monitoring, communication, and counseling for patients with chronic conditions, and psychotherapy as part of behavioral health. The authors conclude that the research focus should shift to how to promote broader implementation and address barriers.

Due to positive results of research and analysis into the effectiveness and potential for cost savings, Deloitte recommends that NDPERS continue coverage of appropriate telehealth services.

## Health Policy Brief

### Realizing the potential of telehealth: Federal and state policy is evolving to support telehealth in value-based care models

Produced by the Deloitte Center for Health Solutions  
and the Deloitte Center for Regulatory Strategy



#### Executive summary

Improving digital connectivity between patients and providers is critical to achieving value-based, patient-centered care.

Many health care organizations are exploring strategies to leverage technology, including telehealth, to increase consumer engagement and focus on prevention and chronic care management outside the traditional physician office visit. Findings from Deloitte's *2016 Survey of US Health Care Consumers* show that interest in and use of telehealth is rising. The policy landscape—including payment policy and care provisions across state lines—is evolving to keep up with consumer demand and technology innovations.

An aging population, increasing chronic illness, the importance of self-care, accelerating health costs, regulatory reform, and new payment models are driving interest and growth in telehealth.<sup>1</sup> Some recent studies show that telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,<sup>2</sup> while others are concerned about its potential to increase costs in a fee-for-service (FFS) environment.<sup>3</sup> Under new value-based payment models that reward outcomes (including lower total cost of care) rather than utilization, telehealth may be a cost-effective solution to provide access to care and, ideally, reduce unnecessary hospital care. Given these trends, providers and health plans should continue to

monitor the complex and ever-evolving policy landscape around telehealth, and consider adopting targeted strategies for telehealth that encourage self-care and increase medication adherence to realize the clinical and economic benefits.<sup>4</sup>

New telehealth policies will likely need to balance potential increased access to services with potential cost increases, as well as payment and licensing changes and what they may mean for provider business models.<sup>5</sup> This policy brief provides an overview of trends in telehealth and consumer interest; the regulatory landscape; and the potential barriers, opportunities, and enablers for telehealth in the coming years. Top-of-mind policies for providers and health plans include:

- Current Medicare payment policy and proposed legislation to change it
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its impact on telehealth
- Centers for Medicare and Medicaid Services (CMS) initiatives that are encouraging telehealth
- Recent Medicaid legislation that encourages telehealth<sup>6</sup> in states and Medicaid managed care
- State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations

### Telehealth has the potential to reduce treatment costs

Telehealth aims to make health care services more accessible to patients so that they can avoid going to the physician's office. Instead, patients can access care any time, via different devices—a web browser, a mobile phone or tablet, or a standalone kiosk in a retail clinic. Telehealth has the potential to improve remote monitoring and self-care strategies and, ultimately, reduce treatment costs by keeping people out of the hospital and emergency room, and reducing physician office visits.

Chronic disease rates are rising, and mental health issues, including depression, are also affecting millions of Americans. The Department of Health and Human Services (HHS) reports that nearly 80 million Americans live in a mental health professional shortage area. Even in urban environments, transportation, time constraints, and the stigma of mental illness often prevent people from seeking mental health services.<sup>7</sup> Telehealth may help address these situations.

A literature review by Rashid Bashshur looked at the evidence related to three conditions prominent in the Medicare population—congestive heart failure (CHF), stroke, and chronic obstructive pulmonary disease.<sup>8</sup> He found that among CHF patients, telemonitoring (transmitting certain physiologic parameters and symptoms from patients at home to their health care provider) was significantly associated with reductions in mortality, ranging from 15 percent to 56 percent relative to traditional care.<sup>9</sup> Studies have also shown that telestroke services—involving a neurologist and an attending nurse communicating via videoconferencing to evaluate the patient's motor skills, view a computed tomography scan, make a diagnosis, and prescribe

treatment—can help stroke patients without readily available access to stroke specialists. Telestroke services could also reduce mortality roughly 25 percent during the first year after the event.<sup>10</sup>

A recent technical brief from the Agency for Healthcare Research and Quality (AHRQ) found that the evidence on telehealth varies across different clinical conditions and health care functions. The report notes that there is sufficient evidence to support the effectiveness of telehealth in some circumstances, including remote monitoring, communication, and counseling for patients with chronic conditions, and psychotherapy as part of behavioral health. The authors conclude that the research focus should shift to how to promote broader implementation and address barriers; and that future research should focus on the use and impact of telehealth in new health care organizational and payment models.<sup>11</sup>

Finally, though data is limited, there is evidence to suggest economic benefits to telemonitoring compared with usual care. One study using data from five telehealth service vendors found:

- In the commercial market, the average estimated cost of a telehealth visit is \$40 to \$50, compared to the average estimated cost of \$136 to \$176 for in-person acute care.
- Patient issues are resolved during the initial telehealth visit an average of 83 percent of the time.

The study concluded that replacing in-person acute care services with telehealth visits reimbursed at the same rate as a doctor's office visit could save the Medicare program an estimated \$45 per visit.<sup>12</sup>

#### What is telehealth?

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care and patient and professional health-related education. Telehealth enables health care providers to connect with patients and consulting practitioners across vast distances. A patient with a chronic disease who uses telehealth may have multiple phone or video sessions with the care team, where health care professionals guide treatment, provide behavioral health support, and monitor progress. See the appendix for definitions of terminology used in this brief.

Telehealth payment policies are evolving as value-based models grow

**Medicare:** Medicare currently pays for telehealth services when the patient being treated is in a health professional shortage area or in a county that is outside any metropolitan statistical area, as defined by the Health Resources and Services Agency and the US Census Bureau, respectively. The telehealth site must be a medical facility, such as a physician's office, hospital, or rural health clinic, and not the patient's home. Medicare will only pay for "face-to-face" interactive video consultation services in which the patient is present, and does not generally cover store-and-forward applications (the transmission of digital images) as they do not typically involve direct interactions with patients (Medicare does have limited coverage of store-and-forward applications in certain regions). Traditionally, Medicare policy restricts coverage to certain reimbursable codes.<sup>13</sup>

As accountable care organizations (ACOs) and other value-based care (VBC) models increase, CMS is experimenting with expanding telehealth—some newer

CMS initiatives give providers more flexibility to use telehealth. In traditional Medicare, coverage is designed around rural populations with little access to other care. However, proposed legislation and experimental programs through CMS are aiming to ease geographic restrictions, which would allow the originating site to be in a person's home and could encourage remote monitoring for patients with chronic conditions.

Since Medicare often sets the standard for coverage in other public and private programs, some stakeholders are advocating for Medicare to update its policy. In May 2016, a group of individual providers and health systems wrote a letter asking the Congressional Budget Office to examine broader sets of telehealth data—from the commercial population, the US Department of Veterans Affairs (VA), and Medicaid—when generating future cost estimates and analyses of telehealth in Medicare.

#### **Telehealth is a critical component of VA's journey toward patient-centered care**

VA is on a journey to become more patient-centric and focused on improving veterans' health and quality. VA's progress in telehealth is virtually unparalleled in other health systems.<sup>14</sup> Early investments and a commitment to increasing access to specialists, incorporating mental health care into primary care, and an integrated provider-payer system that allows for more fluid data flow all support the department's telehealth program.

VA served over 150,000 beneficiaries with telehealth services in 2012.<sup>15</sup> Telehealth was associated with a 25 percent reduction in number of bed days of care and a 19 percent reduction in hospital admissions across all VA patients using telehealth. Overall, VA estimates average annual savings of \$6,500 for each patient that participated in the telehealth program in 2012, which equates to nearly \$1 billion in system-wide savings. VA has conducted studies that show videoconferencing can be successful in treating post-traumatic stress disorder, and that treating mental health issues via telehealth can be effective when compared to face-to-face visits.<sup>16</sup>

Having access to real-time, synchronous expert care through telehealth may help improve access to care, the patient experience, care delivery, and ultimately, health outcomes.

## No new federal telehealth policy but experimentation is happening

Congress has been slow to move on telehealth: Many bills are in the works, but none have passed. Congress did, however, pass MACRA, which included policies that may encourage greater use of telehealth.<sup>17</sup> The Administration has also been focused on telehealth, implementing demonstrations through CMS and making modifications to Medicare Advantage and Medicaid policies at the federal level. Congressional lawmakers have introduced legislation in both the Senate and the House to change Medicare's policies. Some stakeholders say that these bills (described below) have a low chance of passing in their current form,<sup>18</sup> but that certain parts of the bills' provisions may be incorporated into other policy vehicles, including the Senate Finance Committee's expected legislation to address chronic care.<sup>19</sup>

**MACRA:** MACRA may increase telehealth adoption by both clinicians in Alternative Payment Models (APMs) and those remaining in traditional FFS. In April 2016, CMS released the first major regulation under MACRA.<sup>20</sup> According to the proposed rule on the Merit-Based Incentive Payment System (MIPS), Medicare will reward providers' use of telehealth. MIPS will measure performance in four areas: quality; resource utilization; investment in clinical improvement activities; and electronic health records usage. MIPS identifies telehealth and remote patient monitoring (RPM) as a supporting technology for the care coordination subcategory of the clinical practice improvement area.

Telehealth will likely be a useful tool under MACRA because providers will be required to extend their reach beyond the office setting as they aim for more holistic, quality care that avoids costly and unnecessary services. Additionally, MACRA encourages organizations to enter into new payment and delivery models, which should promote collaboration between health plans and hospitals around telehealth and other technology-based patient services.

MACRA directs the Government Accountability Office to study the potential impact of telehealth and remote monitoring on Medicare, with reports due in spring 2017. Though the law holds many encouraging implications for telehealth, some advocates believe that CMS is still showing hesitancy through asking for more evidence around its use.<sup>21</sup>

**Senate activity:** In early 2016, a bipartisan group introduced legislation to remove barriers to Medicare coverage of telehealth through the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act.<sup>22</sup> The CONNECT Act, endorsed by several medical specialty societies, academic institutions, patient advocacy groups, and technology companies, aims to expand the use of telehealth and RPM services in Medicare. Proponents of the legislation believe it will improve quality of care and save costs by making the delivery of health care, information, and education more accessible. The Act includes video conferencing, RPM services to monitor high-risk patients at home, and store-and-forward technologies.

The CONNECT Act strives to help providers transition to MACRA, MIPS, and APMs by eliminating current telehealth and RPM restrictions around geography and lack of reimbursement for face-to-face visits. The Act would also allow RPM use for certain patients with chronic conditions and include telehealth and RPM as basic benefits in Medicare Advantage, without most of the noted restrictions. In a summary sheet for the media, the senators behind the CONNECT Act state that elements of the Act could save \$1.8 billion over 10 years.<sup>23</sup>

**House activity:** The House of Representatives introduced the Medicare Telehealth Parity Act of 2015, bipartisan legislation designed to expand telehealth services under Medicare. This legislation proposes to remove the geographic barriers under current Medicare law and expand the list of providers and related covered services to categories including occupational, physical, respiratory, speech, and audiology therapy.<sup>24</sup> Access to telestroke and RPM for patients with chronic conditions is also part of the legislation, as is access to home health care for dialysis, hospice, and eligible outpatient mental health and home health services. The changes would be phased in to achieve parity between in-person and telehealth coverage.

**CMS demonstrations:** Several CMS initiatives, including the Comprehensive Primary Care Plus (CPC+) Model, the ACO Next Generation model, the Comprehensive Care for Joint Replacement Model (CCJR), and the Bundled Payment for Care Improvement initiative (BPCI), waive certain restrictions around telehealth services (see Table 1 on the following page). Many telehealth advocates and analysts hope these models will demonstrate the value of telehealth services and thereby lay the groundwork for expanding coverage in Medicare.

**Medicare Advantage:** While most of Medicare's 57 million enrollees are covered by FFS Medicare, 31 percent (around 17 million) are enrolled in a Medicare Advantage (MA) plan.<sup>26</sup> MA plans can choose to pay for and provide telehealth services more broadly—as extra benefits—than Medicare FFS.<sup>27</sup> MA plans finance these benefits through their rebate dollars or by charging beneficiaries a supplemental premium.<sup>28</sup> Despite these flexibilities, most MA plans follow the standard Medicare originating site rule.

Anthem and the University of Pittsburgh Medical Center Health Plan offer telehealth benefits beyond traditional FFS benefits to their Medicare Advantage beneficiaries. Part of their motivation is to enhance the consumer experience and make care more accessible.<sup>29</sup> Humana announced in early 2016 that it would offer some telehealth services to its MA beneficiaries, as well.<sup>30</sup> Finally, the Senate Finance Committee is examining telehealth in MA through its work on chronic care management legislation.<sup>31</sup>

**Medicare Payment Advisory Committee (MedPAC) report: More evidence needed on telehealth's value**

MedPAC is an independent, congressionally-appointed body of stakeholders with expertise in health care services financing and delivery. MedPAC makes recommendations to CMS and Congress on payment policy for private health plans participating in Medicare and health care providers serving Medicare beneficiaries. MedPAC published one paper on telehealth, in November 2015, and wrote a chapter on telehealth in its June 2016 report to CMS.<sup>25</sup> In its most recent report, MedPAC again cited the lack of evidence around quality or overall cost-savings for telehealth services. The report said that telestroke may have the strongest evidence. However, MedPAC acknowledged the difficulty in finding sufficient Medicare data on telehealth, given its low use in Medicare as well as inconsistent academic literature, and stated that more evidence is needed around targeted telehealth interventions for specific populations.

"Many telehealth advocates and analysts hope CMS initiatives and models will demonstrate the value of telehealth services and thereby lay the groundwork for expanding coverage in Medicare."

**Table 1. CMS demonstrations involving telehealth**

Initiative	Description	Telehealth implications
CPC+	<p>The risk-based primary care initiative aims to accelerate the shift toward value-based reimbursement and emphasizes health IT and chronic care management.</p> <p>The model builds on the Pioneer ACO Model and the Medicare Shared Savings Program. It sets financial targets, enables greater opportunities to coordinate care, and aims to incentivize high quality care.<sup>32</sup></p>	<p>Participating practices will be responsible for giving patients 24-hour access to care and their information, delivering preventive care, engaging with patients and their families, and coordinating care with hospitals and other clinicians, such as specialists. Telehealth might help meet these requirements.</p> <p>Providers may decide to use the incentive payments to invest in telehealth.<sup>33</sup></p>
ACO Next Generation	<p>The model's goal is to test whether strong financial incentives for ACOs, combined with tools to support better patient engagement and care management, can improve health outcomes and lower expenditures for original Medicare FFS beneficiaries.<sup>34</sup></p>	<p>CMS waives certain telehealth restrictions for ACOs in this model. Originating telehealth sites do not have to be in rural areas or originate from a medical facility (they can originate from the patient's home).</p> <p>ACOs might use telehealth to reduce avoidable hospital readmission rates and triage patients to urgent care or the physician office instead of using the emergency room (ER).<sup>35</sup></p>
CCJR	<p>This model began April 1, 2016. It tests bundled payment and quality measurement for knee and hip replacement episodes of care. Participating hospitals are financially responsible for the cost and quality of these episodes of care.<sup>36</sup></p>	<p>Under bundled payments, providers have the incentive to use any service they believe can reduce the cost of care and improve quality. This model waives the requirements that the originating site for telehealth services must be in a rural area and be a specified medical facility (they can originate from the patient's home).</p>
BPCI	<p>This voluntary program began in 2013 to test bundled payments in Medicare and their ability to reduce Medicare spend while maintaining or improving quality. Participating organizations assume financial and performance responsibility for episodes of care triggered by a hospital admission.<sup>37</sup></p>	<p>Participating organizations can choose among several waivers, including a telehealth waiver similar to the above programs that eases geographic restrictions, though the originating site cannot be the patient's home.</p>

## Federal policies are expanding telehealth in Medicaid

Two recent federal policies provide opportunities for Medicaid providers to expand their telehealth services.

**Federal Medicaid managed care regulations:** In April 2016, CMS released its largest overhaul of Medicaid managed care requirements in more than a decade.<sup>38</sup> The updated regulations aim to modernize Medicaid managed care, align coverage and quality requirements with other sources of health care coverage, strengthen states' delivery system reform, enhance network adequacy standards, and improve the consumer experience. During the public comment period, several commenters recommended that the final rule include coverage for telehealth. CMS noted these comments and agreed that solutions and services related to telehealth could help improve network adequacy in certain areas.

Under the rule, states are required to develop and make publicly available time and distance network adequacy standards for primary care and several specialties, behavioral health and dental care, as well as hospital care. The rule includes factors states should consider in setting standards, including the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.

**Federal policy on use of telehealth in home care:** Also in early 2016, CMS released a final rule updating and clarifying policy around how providers can document Medicaid patients' needs for home health services. These updates have implications for telehealth.<sup>39</sup> CMS' rule allows providers to use face-to-face encounters via telehealth to meet the requirement that a provider sees a patient before ordering home health services. It encourages states to work with the home health provider community to incorporate face-to-face visits in creative and flexible ways, while clarifying that phone calls or emails do not qualify as replacements to the face-to-face encounter.

The rule leaves the states flexibility to define telehealth coverage, including what types to cover, where in the state it can be provided, and how it is to be provided. Several organizations used the public comment period to show their support for telehealth, and, in the final rule, the agency noted its willingness to offer technical assistance to state Medicaid agencies to use telehealth. CMS also noted the need to update Medicaid telehealth guidance, which the agency says is forthcoming.

Policy stakeholders tracking telehealth in Medicaid are largely lauding these recent clarifications and updates. Providers can now examine and appropriately prescribe home health while the patient is remote, which can help streamline processes and maximize resources.

## States telehealth policies are a mix of barriers and incentives

Considerable telehealth oversight takes place at the state level and, in general, states have taken diverse approaches to regulating the services and addressing licensing issues. States regulate telehealth coverage through three major channels, as described in Table 2 on the following page.

Providers seeking to adopt VBC initiatives will likely demand policy changes around telehealth. For example, telehealth could assist physicians operating under payment models that emphasize keeping people out of the hospital. The fact that 16 states have adopted an expedited physician licensure process (the Interstate Medical Licensure Compact) indicates that the shift to VBC is helping to align incentives so that physicians may have an easier time obtaining licenses in multiple states.<sup>40</sup>

"As care delivery models evolve, state policies are progressing to meet consumer and provider demand."

**Table 2. State policy areas around telehealth**

	Description of state policy issue	Examples
<b>Medicaid reimbursement</b>	<p>Medicaid programs in the District of Columbia (DC) and 47 states provide some level of reimbursement for live video, the most traditional telehealth service. Five states offer a full range of services reimbursing for live video, store-and-forward and remote patient monitoring, though the restrictions and limitations vary.</p>	<p>California passed the Telehealth Advancement Act in 2011 to prohibit health plans from requiring a face-to-face visit if a service could be provided via telehealth.</p> <p>This law has led to Medicaid managed care plans reimbursing for a variety of telehealth services including e-consults – electronic communications between a primary care provider and a specialty provider, particularly for patients in medical care homes.</p>
<b>Private insurance parity</b>	<p>Twenty eight states and DC have laws requiring private insurers to reimburse telehealth services at the same rate as in-person services.</p> <p>As payment models evolve toward value-based models, payment parity laws may become less relevant if shared risk and shared savings increase the incentives for plans to encourage the use of telehealth services.</p>	<p>Most states self-insure their state employee health plans, meaning that they would be exempt under traditional private insurer parity requirements.</p> <p>Oregon, however, has amended its parity law to apply to self-insured state plans. Arizona’s parity law requires coverage and reimbursement of telehealth services but limits the requirement to rural areas and seven specific services.<sup>41</sup></p>
<b>Licensing and reciprocity</b>	<p>States and licensing boards govern how and where providers can practice. Most states require physicians to be licensed to practice where they are located and some states require providers using telehealth technology across state lines to have a valid state license in the state where the patient is located.<sup>42</sup></p> <p>Medical provider licensing can limit telehealth programs.<sup>43</sup></p>	<p>In 2015, the Texas Medical Board restricted when physicians can use telephones and video services to provide medical care. Physicians must have a pre-existing relationship established in-person to provide services remotely. While the restrictions do not ban telehealth outright they sharply limit its use.</p> <p>Representatives from telehealth groups and the Texas Medical board have been meeting to see if compromise language can be established. Talks are ongoing.<sup>44</sup></p>

Source: Deloitte analysis of state policies around telehealth; and The Center for Connected Health Policy, “State Laws and Reimbursement Policies,” <http://cchpca.org>.

### Consumer attitudes about telehealth

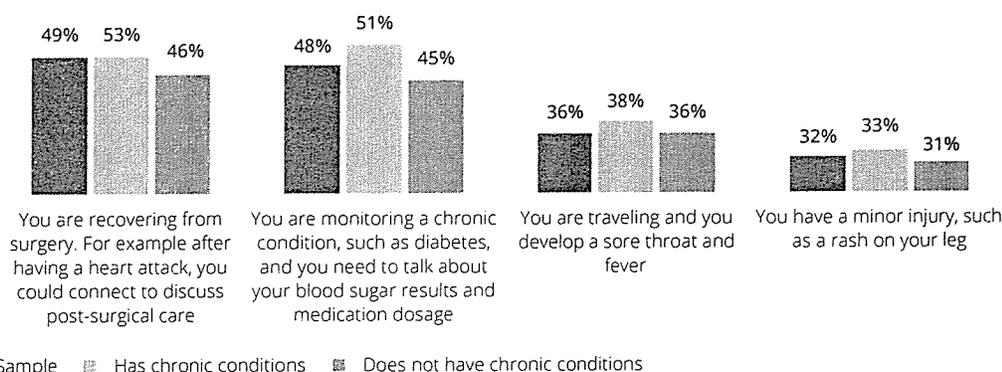
Deloitte's 2016 Survey of US Health Care Consumers<sup>45</sup> shows that consumers are open to telehealth. About half of surveyed consumers, whether they have a chronic condition or not, say they would use telemedicine for post-acute care or chronic condition monitoring. Consumers seem less interested in using telemedicine for acute conditions such as sore throats, rashes, or other minor injuries (Figure 1).

Around one third of surveyed consumers say they have no concerns about using telemedicine. However, 43 percent are concerned about quality of care being

lower than if they saw a provider in person, while 35 percent have privacy and security concerns. Fewer consumers (33 percent) had concerns about the impersonality of telemedicine, while only 15 percent thought the technology would be difficult to learn (Figure 2).

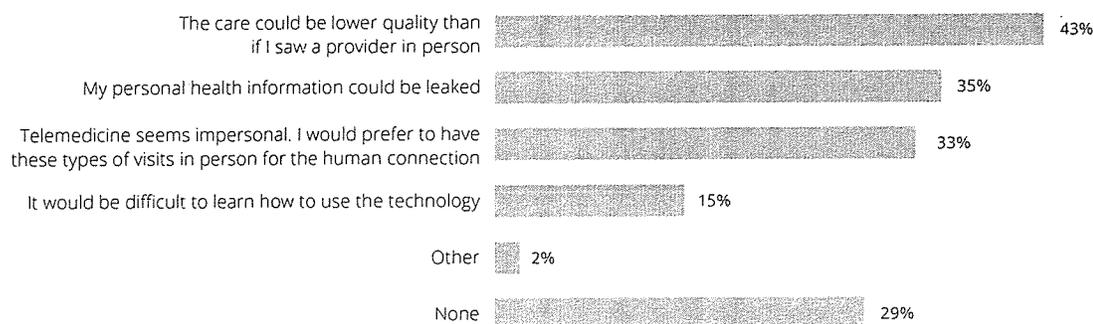
These trends indicate that, similar to banking and retail, health care is not exempt from consumer demand for technology to makes services and information easier to access.

**Figure 1. Likelihood of using telemedicine**



Source: Deloitte Center for Health Solutions 2016 Survey of US Health Care Consumers.

**Figure 2. Barriers to telemedicine use**



Source: Deloitte Center for Health Solutions 2016 Survey of US Health Care Consumers.

## Implications of evolving policies for health care stakeholders

### Health care providers

The American Hospital Association reports that 52 percent of US hospitals were using telehealth in 2013 and another 10 percent were moving toward adopting the platform. A recent policy recommendation from the group includes asking the Senate Finance Committee's Chronic Care Management workgroup to make telehealth the standard of care for people with chronic conditions, rather than a separate path of care alongside traditional in-person visits.<sup>46</sup>

As consumer interest in telehealth continues to grow, and as the federal and state policy landscape evolves to reduce barriers to telehealth, providers may consider investing in telehealth capabilities. In particular, providers may consider strategies for targeted populations who are affected by value-based care models.

Finally, given the complex and ever-evolving policy landscape around telehealth, it would be wise for providers to monitor ongoing federal and state efforts.

### Payers: Health plans and employers

With many health plans developing and investing in capabilities that make health care more convenient and accessible to consumers, it is not surprising that health plan adoption of telehealth is growing. The past year has seen a flurry of activity, with some commercial health plans partnering with telehealth vendors to pilot or expand telehealth services. In addition, more health plans and large employers are interested in incorporating telehealth into their benefit structure.<sup>47</sup> UnitedHealth Group predicts 20 million of its members could access and receive coverage by telehealth providers in the next year; Anthem is expanding its LiveHealth Online program to most individual and employer-based plans, including exchange members in 11 states, and also predicts 20 million members will have telehealth benefits in 2016.<sup>48</sup>

For employers, telehealth may be as much of a human resources topic, used for recruitment and retention, as it is a health care topic. According to a 2015 survey by American Well, one-third of employers offered telehealth in 2015, up from 22 percent in 2014, with 49 percent saying they planned to offer a telehealth benefit in 2016. Reducing medical costs and improving access to care are some of the reasons employers are investing in telehealth; others include employee satisfaction, improving productivity, and attracting new talent.<sup>49</sup>

### Will innovative companies and services beat traditional players to market?

While evidence continues to evolve and accumulate around the ability of telehealth services to meet the health care system's need for cost-effective, quality preventive care and chronic care management, some providers and health plans are interested in meeting consumers where they are.

In the past few years, there has been a proliferation of vendors that offer direct-to-consumer telehealth services. While some consumers may prefer services provided by their physician or health plan, some health care organizations may worry about losing business to these industry disruptors. Meeting consumer demand and innovating their business strategy may be a motivator, beyond cost and quality alone, for broadening telehealth adoption.

Source: Darius Tahrir, "Telehealth services surging despite questions of value," *Modern Healthcare*, February 21, 2015

The Affordable Care Act (ACA) requires that health plans serving health insurance exchanges meet standards for network adequacy. As health plans move toward narrower provider networks for exchange plans in order to reduce premiums, telehealth is one important strategy that could help health plans meet network adequacy standards more cost-effectively—and help providers deliver care to underserved areas more efficiently.<sup>50</sup>

Like providers, health plans may want to pay attention to the evolving policy landscape to confirm that their efforts mirror those of CMS and that they are not burdening providers with different requirements. There is an opportunity for health plans to play a leading role in pioneering telehealth strategies, as the federal government will likely continue to look to the commercial market for additional telehealth quality and cost-effectiveness data.

## Appendix

### Telehealth terminology:

- **Telehealth vs. telemedicine:** According to the Office of the National Coordinator for Health Information Technology, telehealth refers to a broader scope of remote healthcare services than telemedicine, which refers specifically to remote clinical services. Telehealth can refer to remote nonclinical services, such as provider training and continuing medical education, in addition to clinical services.
- **Synchronous telehealth** requires presence of both parties (may be a patient and a nurse practitioner consulting with a specialist via a live audio/video link, or a clinician and a patient communicating via videoconference) to be communicating in real time.
- **Asynchronous or store-and-forward telehealth** refers to the transmission of digital images, as in radiology or dermatology, for a diagnosis.

## References

1. Harry Greenspun and Sheryl Coughlin, "mHealth in an mWorld: How mobile technology is transforming health care," Deloitte Center for Health Solutions, 2014.
2. Dale H. Yamamoto, "Assessment of the feasibility and cost of replacing in-person care with acute care telehealth services," Alliance for Connected Care, December 2014.
3. Susan D. Hall, "MedPAC concerned increased telehealth reimbursement could lead to unnecessary costs," Fierce Health Care, March 14, 2016.
4. Harry Greenspun, Casey Korba, Sunandan Banerjee, "Accelerating the adoption of connected health," Deloitte Center for Health Solutions, November 2014.
5. Bob Herman, "Virtual reality: More insurers are embracing telehealth," Modern Healthcare, February 20, 2016.
6. Jonah Comstock, "CMS okays telehealth for face-to-face Medicaid visits," Mobihealth News, January 28, 2016.
7. Amy Novotney, "A new emphasis on telehealth," American Psychological Association, June 2011.
8. RL Bashshur et al, "The empirical foundations of telemedicine interventions for chronic disease management," Journal of Telemedicine and e-Health, September 20, 2014.
9. Krista Drobac and Clif Gaus, "Connected care is key to accountable care: The case for supporting telehealth in ACOs," The American Journal of Accountable Care, June 2014.
10. RL Bashshur et al, "The empirical foundations of telemedicine interventions for chronic disease management," Journal of Telemedicine and e-Health, September 20, 2014.
11. AM Totten, DM Womack, KB Eden, MS McDonagh, JC Griffin, S Grusing, and WR Hersh. "Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews." Technical Brief No. 26. AHRQ Publication No.16-EHC034-EF, Agency for Healthcare Research and Quality, June 2016.
12. Dale H. Yamamoto, "Assessment of the feasibility and cost of replacing in-person care with acute care telehealth services," Alliance for Connected Care, December 2014.
13. HHS, CMS, "Medicare Learning Network: Telehealth Services," 2015.
14. Terri Cooper, "A glimpse into the future of health care at VA," Deloitte Center for Health Solutions Health Care Current, April 19, 2016.
15. American Hospital Association, "Telehealth: Helping hospitals deliver cost-effective care," 2016.
16. John Paul Jameson, Mary Sue Farmer, Katharine J. Head, John Fortney, Cayla R. Teal, "VA community mental health service providers' utilization of and attitudes toward telemental health care: The gatekeeper's perspective," The Journal of Rural Health, August 2011.
17. Public Law 114-10 (April 16, 2015)
18. GovTrack.US, S.2484: CONNECT for Health Act.
19. Mark Weideman and Jonathan Nelson, "What digital health should know about the CONNECT Act's effect on telemedicine," Rock Health, March 10, 2016.
20. Public Law 114-10 (April 16, 2015)
21. Dianne Bourque, Thomas S. Crane, Ellen Janos & Sarah Beth S. Kuyers, "MACRA's Advancement of EHR interoperability and telehealth," Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., April 24, 2015.
22. US Congress, S.2484 CONNECT for Health Act, introduced February 2, 2016.
23. Senator Brian Schatz, CONNECT For Health Act one-pager, February 3, 2016.
24. US Congress, H.R. 2948 Medicare Telehealth Parity Act of 2015, introduced July 7, 2015.
25. Medicare Payment Advisory Committee, Reports, 2016.
26. Kaiser Family Foundation, "Medicare Advantage," May 11, 2016.
27. Katie Horton, Mary-Beth Malcarney, Naomi Seiler, "Medicare payment rules and telemedicine," Public Health Report, March-April 2014.
28. Medicare Payment Advisory Committee, Report to the Congress: Medicare and the Health Care Delivery System, June 2016.
29. Phil Galewitz, "Medicare slow to adopt telemedicine due to cost concerns," Health IT News, June 24, 2015.
30. David Pittman, "Major insurer adds telemedicine in Medicare Advantage plans," Politico, January 11, 2016.
31. The United States Senate Committee on Finance, Letter to stakeholders, May 22, 2015.
32. Centers for Medicare and Medicaid Services, Comprehensive Primary Care Model, 2016.
33. Deborah A. Jeffries, "Progress in reimbursement for telehealth and new primary care model," Electronic Health Reporter, May 16, 2016.
34. Patrick Conway, "Building on the success of the ACO model," The CMS Blog, March 10, 2015.
35. Studies have shown that a quarter of all ER visits are for nonemergent care, resulting in otherwise avoidable health costs. Using telehealth to increase appropriate care sites is one strategy of ACO care coordination.
36. Centers for Medicare and Medicaid Services, Comprehensive Care for Joint Replacement Model, 2016.
37. Centers for Medicare and Medicaid Services, Bundled Payments for Care Improvement (BPCI) Initiative: General Information, 2016.
38. Centers for Medicare and Medicaid Services, 42 CFR Parts 431, 433, 438, 440, 457 and 495, Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, Federal Register, 2016.
39. Ibid.
40. Interstate Medical Licensure Compact, About the Compact, 2016.
41. Latoya Thomas and Gary Capistrant, "State Telemedicine Gaps Analysis: Coverage and Reimbursement," American Telemedicine Association, January 2016.
42. Centers for Medicare and Medicaid Services, Telemedicine, 2016.
43. Ibid.
44. Edgar Walters, "Doctors, telemedicine companies meet to plot new course," The Texas Tribune, June 8, 2016.
45. The Deloitte 2016 Survey of US Health Care Consumers has a nationally representative sample of 3,751 adults.
46. Mark Weideman and Jonathan Nelson, "What digital health should know about the CONNECT Act's effect on telemedicine," Rock Health, March 10, 2016.
47. Brian Dolan and Jonah Comstock, "In depth: The changing relationship of health plans and virtual visit services," Mobile Health News, September 11, 2015.
48. Bruce Japsen, "Health industry dials up telehealth for growth," The Motely Fool, June 11, 2015.
49. Claudia Rimerman, "What do employers want from telehealth: Insights from American Well's 2015 Employer Benchmark Survey," BenefitsPro, February 11, 2016.
50. Sandy Ahn, Sabrina Corlette, and Kevin Lucia, "Can telemedicine help address concerns with network adequacy? Opportunities and challenges in six states," Robert Wood Johnson Foundation and Urban Institute issue brief, April 2016.

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## Acknowledgements

We wish to thank Anne Phelps, Sarah Thomas, Jessica Nadler, Danielle Moon, Julie Barnes, Krista Drobac, Mario Gutierrez, Bernard Harris, Kofi Jones, Claire Cruse, Leslie Korenda, Christina DeSimone, Lauren Wallace, and the many others who contributed their ideas and insights to this project.

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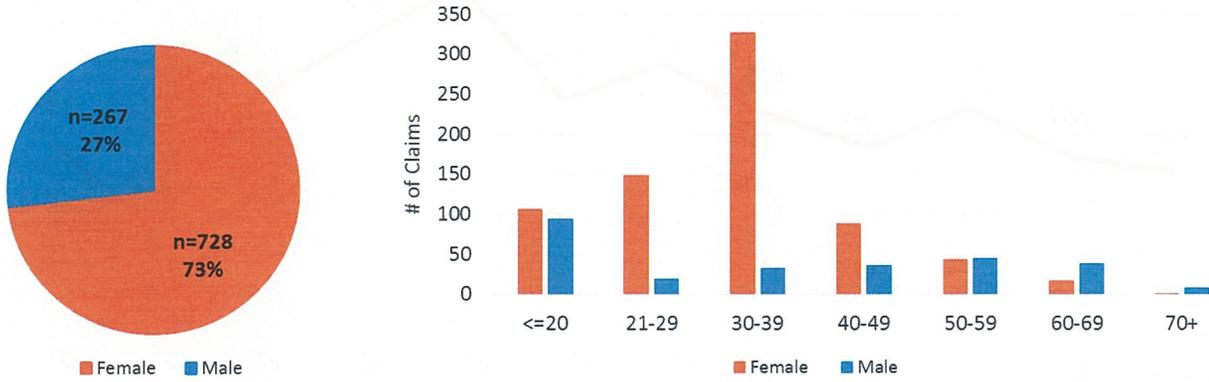
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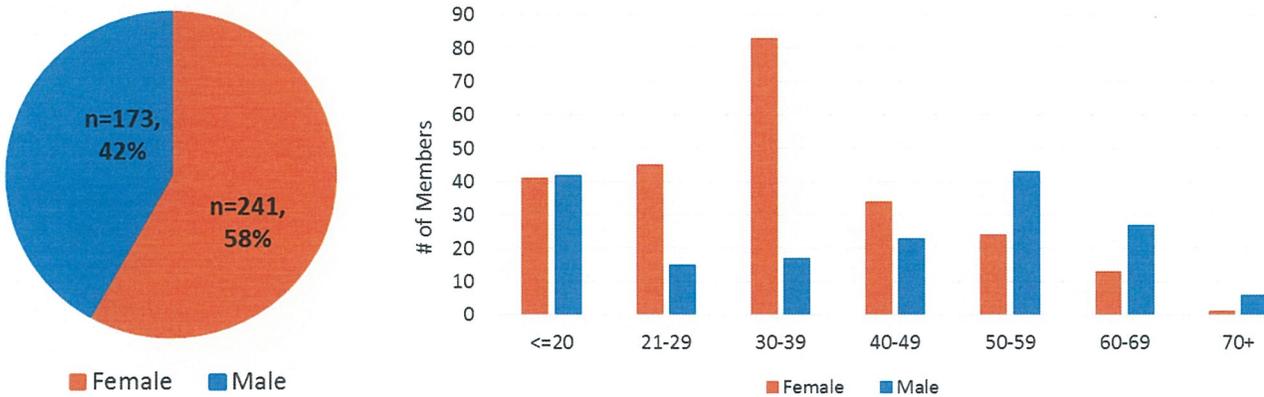
# NDPERS Telehealth Summary

Claims incurred between 7/1/15 and 6/30/16, paid through 8/9/16

## Total Telehealth Claims by Gender and Age Bands

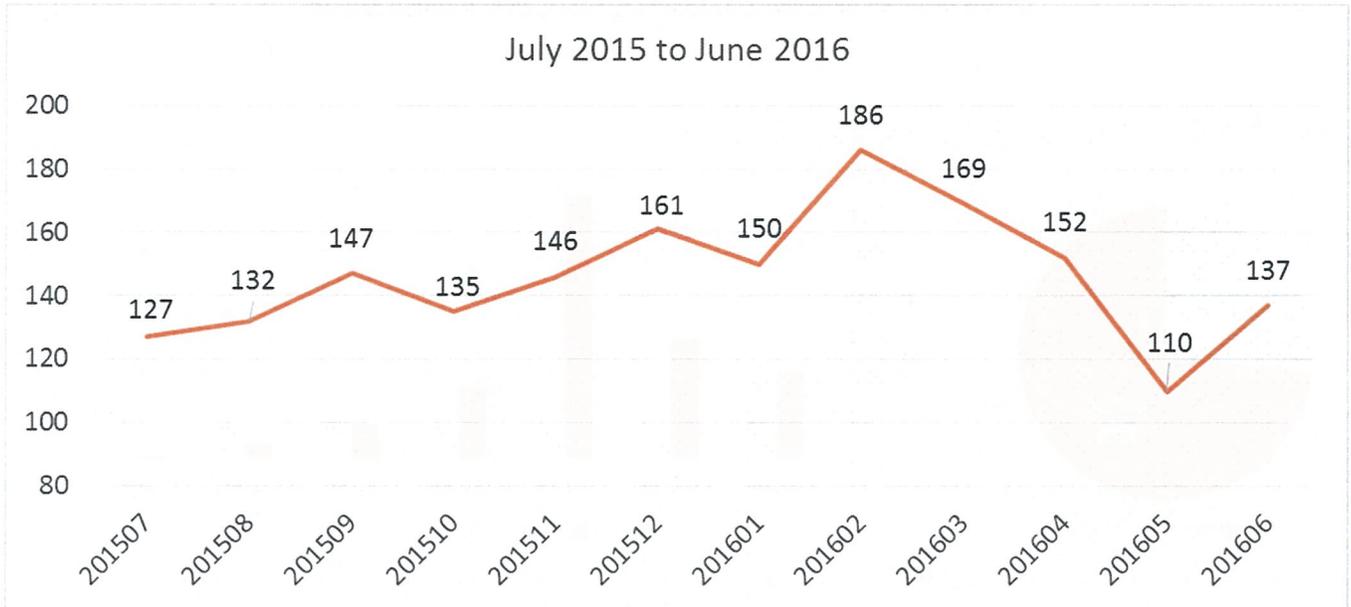


## Total Telehealth Members by Gender and Age Bands



## Claims over Time

Claims incurred between 7/1/15 and 6/30/16, paid through 8/9/16



*Note that May and June claims may not reflect actual volume due to limited runout period*

## Member State v Provider State

Provider State	Member State			Grand Total
	MN	ND	SD	
ND	10	801	0	811
MN	12	86	0	98
NULL	0	28	0	28
IL	2	23	0	25
MT	0	25	0	25
SD	3	15	3	21
NE	0	8	0	8
WA	0	1	0	1
IA	0	4	0	4
ID	1	0	0	1
<b>Grand Total</b>	<b>28</b>	<b>991</b>	<b>3</b>	<b>1022</b>

Excludes CPT code 'Q3014'

- 78.4% of the telehealth claims were between a provider and a member (resident) both in the state of North Dakota. 8.4% of the telehealth claims were between a ND resident and a MN provider.

## Member State/City v Provider State/City

Count of Claim#	Member City									Grand Total	
Provider City	GRAND FORKS	BISMARCK	WILLISTON	JAMESTOWN	MINOT	DEVILS LAKE	DICKINSON	Other ND	MN	SD	
<b>ND</b>											
BISMARCK		11	19		14		2	11			57
DEVILS LAKE								2			2
DICKINSON							8	7			15
FARGO	143	59	21	46	12	1	25	145	4		456
GRAND FORKS	12	38				30		97	6		183
JAMESTOWN				4				3			7
MINOT			19	9	29			14			71
VALLEY CITY				1				2			3
WILLISTON			1				10	5			16
WEST FARGO								1			1
<b>MN</b>	2	2	1	10		5	4	62	12		98
<b>IL</b>	12							11	2		25
<b>MT</b>			22		1			2			25
<b>SD</b>		5		2				8	3	3	21
<b>NE</b>					8						8
<b>WA</b>								4			4
<b>FL</b>		1									1
<b>IA</b>									1		1
<b>ID</b>		1									1
<b>NULL</b>						18		10			28
<b>Grand Total</b>	<b>169</b>	<b>117</b>	<b>83</b>	<b>72</b>	<b>64</b>	<b>54</b>	<b>49</b>	<b>384</b>	<b>28</b>	<b>3</b>	<b>1023</b>

Excludes CPT code 'Q3014'

## Claims by Provider Specialty

Top 10 Provider Specialties by Total Charged. These top 10 specialties represent 85% of total claims.

Provider Specialty	Claims	Total Charged
REPRODUCTIVE ENDOCRINOLOGY (OBSTETRICS AND GYNECOLOGY)	341	\$57,429
PSYCHIATRY (PSYCHIATRY AND NEUROLOGY)	211	\$55,883
CHILD AND ADOLESCENT PSYCHIATRY (PSYCHIATRY AND NEUROLOGY)	71	\$29,068
PSYCHOLOGIST	75	\$14,824
INTERNAL MEDICINE	46	\$6,102
CLINICAL NURSE SPECIALIST (PSYCHIATRIC OR MENTAL HEALTH)	27	\$5,167
NURSE PRACTITIONER	26	\$5,065
FAMILY MEDICINE	19	\$4,745
NP - OBSTETRICS AND GYNECOLOGY	32	\$4,664
SLEEP MEDICINE (FAMILY MEDICINE)	26	\$4,530
<b>Grand Total</b>	<b>874</b>	<b>\$187,477</b>

*Excludes CPT code 'Q3014'*

## Claims by Provider Group

Top 15 Provider Groups by Total Charged. These top 15 providers represent 87% of total claims.

Provider Group	Claims	Total Charged
SANFORD MEDICAL CENTER FARGO PROF	427	\$74,544
ALTRU HEALTH SYSTEM PROFESSIONAL	241	\$35,345
NORTH CENTRAL HUMAN SERVICE CENTER	48	\$20,217
NORTHWEST HUMAN SERVICE CENTER	36	\$17,095
SANFORD CLINIC FARGO REGION	252	\$14,794
CENTER FOR PSYCHIATRIC CARE	104	\$11,761
BADLANDS HUMAN SERVICE CENTER	17	\$7,839
VA MEDICAL CENTER	41	\$7,564
SANFORD BISMARCK	190	\$7,180
NORTHLAND CHRISTIAN COUNSELING CENTER	38	\$6,415
PSYCHIATRY NETWORKS	36	\$4,260
ESSENTIA HEALTH	16	\$3,931
WHITNEY SLEEP DIAGNOSTICS AND CONSULTANTS	42	\$3,906
SANFORD THIEF RIVER FALLS	14	\$3,385
BILLINGS CLINIC	24	\$3,288
<b>Grand Total</b>	<b>1,526</b>	<b>\$221,524</b>

## Claims by Diagnosis

Top 15 Diagnoses by Total Charged. These top 15 diagnoses represent 42% of total claims.

<b>Diag 1</b>	<b>Diagnosis Description</b>	<b>Claims</b>	<b>Total Charged</b>
N97.9	Female infertility, unspecified	69	\$12,050
F33.1	Major depressive disorder, recurrent, moderate	35	\$10,704
F41.1	Generalized anxiety disorder	49	\$10,507
N97.0	Female infertility associated with anovulation	52	\$8,512
F90.2	Attention-deficit hyperactivity disorder, combined type	27	\$7,811
F33.9	Major depressive disorder, recurrent, unspecified	24	\$6,571
F84.0	Autistic disorder	14	\$5,533
628	Female infertility associated with anovulation	38	\$5,323
F32.1	Major depressive disorder, single episode, moderate	11	\$5,053
G47.33	Obstructive sleep apnea (adult)(pediatric)	30	\$4,764
F32.9	Major depressive disorder, single episode, unspecified	18	\$4,743
296.32	Major depressive affective disorder, recurrent episode, moderate	11	\$3,648
628.9	Infertility, female, of unspecified origin	22	\$3,307
F90.9	Attention-deficit hyperactivity disorder, unspecified type	13	\$3,187
Z34.01	Encounter for supervision of normal first pregnancy, first trimester	18	\$2,917
<b>Grand Total</b>		<b>431</b>	<b>\$94,627</b>

<b>Summary Category</b>	<b>Claims</b>	<b>Total Charged</b>
Female Infertility & Birthing	199	\$32,109
Behavioral Health	202	\$57,755
Sleep Apnea	30	\$4,764
<b>Grand Total</b>	<b>431</b>	<b>\$94,627</b>

*Excludes CPT code 'Q3014'*

## Bill 120 – TeleHealth

### 54-03-28. Health insurance mandated coverage of services

- a. The measure is effective through June thirtieth of the next odd-numbered year following the year in which the legislative assembly enacted the measure, and after that date the measure is ineffective.
- b. The application of the mandate is limited to the public employees health insurance program and the public employee retiree health insurance program.
- The application of such mandate begins with every contract for health insurance which becomes effective after June thirtieth of the year in which the measure becomes effective.
- c. That for the next legislative assembly, the public employees retirement system shall prepare and request introduction of a bill to repeal the expiration date and to extend the mandated coverage or payment to apply to accident and health insurance policies. The public employees retirement system shall append to the bill a report regarding the effect of the mandated coverage or payment on the system's health insurance programs. The report must include information on the utilization and costs relating to the mandated coverage or payment and a recommendation on whether the coverage or payment should continue. For purposes of this section, the bill is not a legislative measure mandating health insurance coverage of services or payment for specified providers of services, unless the bill is amended following introduction so as to change the bill's mandate.

# Deloitte Review

- Female infertility, behavioral health and sleep apnea were the top three diagnoses for the first year of this program. Telehealth has enabled patients in the rural and outlying areas of the state to continue to see their specialist residing in one of the state's four major cities without having to travel hundreds of miles.

# Deloitte Review

- From July 1, 2015 to June 30, 2016 there were 1022 total telehealth claims and the originating site charge.
- • 551 of these claims refer to the professional service, totaling \$63,040.
- • 387 of these claims refer to the originating site charge.
- • The originating site charge includes being checked in by a nurse and the use of a secure video connection between the member and Physician.
- • 74.4% of telehealth claims were between a provider and member/resident who were both in the state of North Dakota
- • 8.4% of the telehealth claims were between an ND resident and a MN provider

# Deloitte Review

- Top 10 Provider Specialties:
  - 1. Reproductive Endocrinology (OB/GYN)- 341 claims
  - 2. Psychiatry- 211 claims
  - 3. Child & Adolescent Psychiatry- 71 claims
  - 4. Psychology- 75 claims
  - 5. Nurse Practitioner (OB/GYN)- 32 claims
  - 6. Sleep Medicine- 26 claims
  - 7. Family Medicine- 19 claims
  - 8. Internal Medicine- 46 claims
  - 9. Clinical Nurse Specialist (Psychiatric/Mental Health)- 27 claims
  - 10. Nurse Practitioner- 26 claims

# Deloitte Review

- *Deloitte Health Policy Brief – Realizing the potential of telehealth*

**Deloitte.**

Health Policy Brief

Realizing the potential of telehealth:  
Federal and state policy is evolving to support  
telehealth in value-based care models

Produced by the Deloitte Center for Health Solutions  
and the Deloitte Center for Regulatory Strategy



#### Executive summary

Improving digital connectivity between patients and providers is critical to achieving value-based, patient-centered care.

Many health care organizations are exploring strategies to leverage technology, including telehealth, to increase consumer engagement and focus on prevention and chronic care management outside the traditional physician office visit. Findings from Deloitte's 2016 Survey of US Health Care Consumers show that interest in and use of telehealth is rising. The policy landscape—including payment policy and care provisions across state lines—is evolving to keep up with consumer demand and technology innovations.

An aging population, increasing chronic illness, the importance of self-care, accelerating health costs, regulatory reform, and new payment models are driving interest and growth in telehealth.<sup>1</sup> Some recent studies show that telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,<sup>2</sup> while others are concerned about its potential to increase costs in a fee-for-service (FFS) environment.<sup>3</sup> Under new value-based payment models that reward outcomes (including lower total cost of care) rather than utilization, telehealth may be a cost-effective solution to provide access to care and, ideally, reduce unnecessary hospital care. Given these trends, providers and health plans should continue to

monitor the complex and ever-evolving policy landscape around telehealth, and consider adopting targeted strategies for telehealth that encourage self-care and increase medication adherence to realize the clinical and economic benefits.<sup>4</sup>

New telehealth policies will likely need to balance potential increased access to services with potential cost increases, as well as payment and licensing changes and what they may mean for provider business models.<sup>5</sup> This policy brief provides an overview of trends in telehealth and consumer interest; the regulatory landscape; and the potential barriers, opportunities, and enablers for telehealth in the coming years. Top-of-mind policies for providers and health plans include:

- Current Medicare payment policy and proposed legislation to change it
- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its impact on telehealth
- Centers for Medicare and Medicaid Services (CMS) initiatives that are encouraging telehealth
- Recent Medicaid legislation that encourages telehealth<sup>6</sup> in states and Medicaid managed care
- State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations

## Deloitte Recommendation

*“Due to positive results of research and analysis into the effectiveness and potential for cost savings, Deloitte recommends that NDPERS continue coverage of appropriate telehealth services.”*

## Next Steps

- *Will be reviewed by the PERS Board at the September and October meetings*