17.0120.01000

FISCAL NOTE

Requested by Legislative Council
12/23/2016

Bill/Resolution No.: SB 2052

1 A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2015-2017 Biennium		2017-2019 Biennium		2019-2021 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues	$0	$0	$0	$0	$0	$0
Expenditures	$0	$0	$0	$0	$0	$0
Appropriations	$0	$0	$0	$0	$0	$0

1 B. **County, city, school district and township fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

	2015-2017 Biennium	2017-2019 Biennium	2019-2021 Biennium
Counties	$0	$0	$0
Cities	$0	$0	$0
School Districts	$0	$0	$0
Townships	$0	$0	$0

2 A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

A bill to provide that an insurer cover telehealth services the same as health services delivered in-person.

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

Telehealth services are currently covered under the NDPERS Health Plan, so there would be no additional cost.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*

A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

N/A

B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

N/A

C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation or a part of the appropriation is included in the executive budget or relates to a continuing appropriation.*

N/A

Name: Bryan Reinhardt
Agency: NDPERS
Telephone: 701-328-3919
Date Prepared: 12/27/2016

2017 SENATE HUMAN SERVICES

SB 2052

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2052
1/9/2017
Job Numbers 26684

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature	Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill Relating to Health insurance coverage and retirement telehealth services

Minutes: Attachments: 1-5

Chairman Lee: Opened the hearing on SB 2052, all members were present.

Sparb Collins, Executive Director, North Dakota Public Employees Retirement System: See Attachment #1 for testimony to explain the bill and in support of the bill. (1:18-9:05)

Senator Anderson: It doesn't appear that there is a large dollar amount involved in the Telehealth services, is that accurate?

Sparb Collins: At this point, No. As time goes on I do not know how Telehealth will be expanded in the medical system and what other uses there will be. It is fairly new. At this point I do not see a lot of cost but I do see opportunities that this is a service that is going to become even more sophisticated and as it does it may get more expansive in use. It is helpful for our rural members.

Senator Anderson: Can you tell whether the recommendation is based on better care, customer satisfaction or lower cost?

Sparb Collins: I can comment but I am not sure that I have an answer for you. Considering customer satisfaction, we have not had any complaints from customers of Telehealth. That is more antidotal than quantitative but it is all I can share on that. The cost of the service is basically the same as it would be in person. As to the quality, this service is being accessed through the same providers that you would have a visual with, so I would assume it is the same level of quality care?

Senator Kreun: In your summary, it appears that your claims in the one female age bracket is higher, why is that?

Sparb Collins: On Page A25, the diagnosis breakdown on total charge and claims is there and this will give you an idea of claims usage.

Senator Lee: This is a tool, and it is not a replacement. It is a tool to allow access into the rural areas. If you look on A25 at the various diagnosis descriptions, you will see how many of them are behavioral and mental health related issues. It is a big piece of the action there. If we can possibly reach out through Telehealth that we are unable to with face to face meetings, I do not think the cost would be as expensive as if they go untreated and we end up having in patient care and much more serious illness that needs additional care and treatment that will be insured. I am not looking at Telehealth as being an additional cost; it is an alternative cost for the same service to be provided to those that can make use of it in a place where it might not otherwise be used.

Senator Piepkorn: Might it be a choice out of privacy or comfort level rather than convenience?

Sparb Collins: Yes, I cannot tell you what number of these claims are that way but there is nothing in the benefit that restricts those reasons.

Senator Anderson: Looking to the future, did you identify any barriers or people who sought services that were not available through Telehealth?

Sparb Collins: I am not able to answer that. We were required to look at telehealth and our plan. There are probably other areas where there are things that maybe we don't offer that were not highlighted here. That maybe we did not come across. We looked at the PERS experience to be able to share our experience.

Senator Lee: The law requires that something like this be used first in the PERS system. It is sort of our little pietry dish to see if programs work and then if it looks like a good idea you make recommendations and it would be moved out to the general population. We're not big on mandates in ND without having research. How many members are in PERS?

Sparb Collins: We have about 68,000 to 69,000 members; that is active and retired. We provide services to the state of ND as well as political subdivisions and retirees.

Chairman Lee: It becomes a good opportunity to see how it works.

Senator Heckaman: On the bottom of page A24, can you talk more about how the top 15 providers and the out of state providers connect with our state employees? Are they providing specific services?

Sparb Collins: They are likely specific services that they are seeking but all we are referring to here is where those services were given. Our plan right now does not have a limitation that would say to a member that they cannot utilize out of state services.

Senator Heckaman: Do you know if they were veteran's services?

Sparb Collins: We could find that out but I do not know offhand.

Chairman Lee: I would be interested to know that answer. (19:50)

Cheryl Rising, Family Nurse Practitioner and Legislative Liaison, the ND Nurse Practitioner Association: See Attachment #2 for testimony in support of the bill. (21:00-(22:00) See Attachment # 3 for testimony referenced and brought in in favor of the bill for Jennifer Tinkler. (23:25)

Marsha Waind, Co-Chair, ND Telehealth Work Group of the ND Health Information Network: See Attachment #4 for testimony in support of the bill. (26:20)

Marnie Walth, Sanford Health: See Attachment #5 for testimony in neutral capacity on the bill. (27:10-28:50)

Chairman Lee: Closed the hearing on SB 2052.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2052
1/9/2017
Job Number 26686

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature

Explanation or reason for introduction of bill/resolution:

Health insurance coverage and retirement Telehealth Services.

Minutes: No Attachments

Chairman Lee: Reopened the hearing on SB 2025. (Commented on the practice of things being reviewed by the PERS system and then determining whether to move forward as well as the fact that Sanford is already practicing what is being addressed.)

Senator Kreun: With that, are we going to hinder it if we pass this and stifle the innovation part? Technology moves a lot faster than we do.

Senator Lee: I do not think that it is going to stifle the use of other technology because it does not ban other things from being done. It just says that this particular on will move on to private insurers (that are already doing it) since the experience with PERS has been positive. I do appreciate the recommendation from the Employee Benefits Committee also in suggesting that we move it forward.

Senator Kreun: If something comes along and it is better than what we are putting in here at this point in time, they can still use it?

Chairman Lee: We are not being specific to any particular kind of stuff.

Senator Kreun: They talked about the cell phone working better than the video portion though.

Chairman Lee: That is why we need to leave the technology part in that was mentioned.

Senator Kreun: Can we use something new that is not already in here that we have used before so that we don't stifle any innovation or new technologies that come along?

Chairman Lee: Asked if anyone present would like to comment if they see anything in the bill that is restricting.

Megan Smith, BCBS (2:55) I don't know that it is going to stifle; I think that the law, once it is in code, will likely be out of date because of what is happening. Insurers have been covering Telehealth since the early 90's. This is just one of those bills that is frankly unnecessary. In terms of the Employee Benefits Committee, to provide context, because of the way the process is done, we would have had to go back into PERS. There is some language cleanup that could happen in terms of some of the terminology needing to be updated.

Chairman Lee: Isn't that in rule?

Marnie Walth, Sanford Health: I would generally say no, those specifics aren't in rule.

Chairman Lee: I think what the issue is that we don't want anything in here to be so rigid, and I totally agree with that concept. I don't know that I want to see in statute who gets to do stuff. I think that is the responsibility of the scope of practice areas of each of the boards. The insurers are determining what types of procedures they will cover.

Marnie Walth: I agree. When I read the bill and it spoke to that coverage would be the same for Telemedicine delivery as it is for in person, I was concerned about that but then immediately after there was the language that is very specific.

Chairman Lee: Asked the committee if they had any further questions and there were none.

Senator Heckaman: Moved a Do Pass, with the understanding that I share Senator Kreun's concern that we are making sure we are covering enough but not too much. I am comfortable with Sparb Collin's testimony that we need to have this in code to cover what we did last session.

Senator Anderson: Seconded.

A Roll Call Vote Was Taken: 7 yeas, 0 nays, 0 absent.

Motion carried.

Senator Larsen will carry the bill.

Date: 1/9/2017
Roll Call Vote #: 1

2017 SENATE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. 2052

Senate Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☒ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Sen. Heckaman Seconded By Sen. Anderson

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee (Chairman)	X		Senator Joan Heckaman	X	
Senator Oley Larsen (Vice-Chair)	X		Senator Merrill Piepkorn	X	
Senator Howard C. Anderson, Jr.	X				
Senator David A. Clemens	X				
Senator Curt Kreun	X				

Total (Yes) 7 No 0

Absent 0

Floor Assignment Sen. Larsen

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2052: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** (7 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2052 was placed on the Eleventh order on the calendar.

2017 HOUSE HUMAN SERVICES

SB 2052

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2052
3/7/2017
28802

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for introduction of bill/resolution:

Relating to public employee's retirement system uniform group insurance coverage of telehealth services.

Minutes: 1, 2, 3, 4, 5, 6

Chairman Weisz: Called the committee to order.
Attendance taken.
Opened the hearing on SB 2052.
Is there any testimony in support of SB 2052?

Sharon Schiermeister, CEO for ND Public Employees Retirement System (NDPERS
(Attachment 1)
5:11
Chairman Weisz: Are there any questions from the committee?
Further testimony in support of SB 2052?

Andy Askew, Essentia Health
Introduced Maureen Ideker to offer testimony in support of SB 2052

Maureen Ideker RN, BSN, MBA
(Attachment 2)
10:45
Chairman Weisz: Are there any questions from the committee?

Representative Porter: Inside of telehealth is there any where that telehealth is not covered that this bill would advance the coverage or is the payer system already covering it?

M. Ideker: In the 3 areas that I did highlight that is currently not covered. It would be covered under the ND PERS bill that was recommended for endorsement though.

Representative Porter: So any audiologist currently cannot use the service and cannot be reimbursed by any third party payers?

M. Ideker: That is correct. No they are not covered. There might be some commercial payers that do pay for that, but as a general rule no. The audiologists, even infant audiologist, the ones that diagnose right when the baby is born, are not reimbursed. The technology is there and can be used for diagnostic testing, but it is not a reimbursable service so it is not provided.

Chairman Weisz: Is there further testimony in support of SB 2052?

Cheryl Rising, Family Nurse Practitioner
(Attachment 3)

Jennifer Tinkler, FNP
(Attachment 4)
She was not here, but Cheryl Rising presented her testimony.
14:37

Chairman Weisz: Are there any questions from the committee?
Chairman Weisz: Further testimony in support?

Mike Chaussee, AARP of ND
(Attachment 5)

Chairman Weisz: Are there any questions from the committee?
Is there further testimony in support of SB 2052?

Chairman Weisz: Is there any testimony in opposition?
Is there any neutral testimony on SB 2052?

Marnie Walth, Sanford Health
(Attachment 6)

Chairman Weisz: Are there any questions from the committee?

Chairman Weisz: Is there anyone else here with neutral testimony?
Seeing none, we will close the hearing on SB 2052

2017 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Union Room, State Capitol

SB 2052
3/8/2017
28935

☐ Subcommittee
☐ Conference Committee

Committee Clerk Signature Judy Kepple

Explanation or reason for introduction of bill/resolution:

Relating to individual and group health insurance coverage of telehealth services; relating to public employee's retirement system uniform group insurance coverage of telehealth services.

Minutes: 1

Chairman Weisz: Committee we will open the discussion on SB 2052. The amendment is printing. Sanford did have some concerns. (Attachment 1)
Chairman Weisz: On page 2 lines 17 – 20. If the costs of the telehealth are less than it would be in person, why would they be required to reimburse at the same rate?
So we can at least take a look at these and see what we think. There should be a period on line 19 after "by means of telehealth". They will then delete the rest. What it is saying is that you have to provide the coverage, but it doesn't necessarily have to be the same rate, because there are differences with telehealth. Then on page 2 line 20 remove the whole line.

Representative P. Anderson: How about page 2 line 24 – 26?

Chairman Weisz: That would be ok, because they would negotiate

Vice Chairman Rohr: I move the amendment.

Representative Skroch: second.

Chairman Weisz: Ok we have a motion and a second. Does everyone understand the amendment?

We will have a voice vote to accept the amendment.
Voice vote carried.

Chairman Weisz: Any further amendments? This is what we did in 2015 except we are making it state wide.

Representative Skroch: Do pass as amended on SB 2052.

Representative Seibel: Second.

Chairman Weisz: Ok committee, we have a motion and a second for a do pass as amended on SB 2052. Is there any further discussion?

Clerk will call the roll for a do pass as amended on SB 2052

Roll call vote taken yes 14 No 0 Absent 0

Chairman Weisz: Motion carried. Do I have a volunteer to carry this one?

Representative D. Anderson: I will.

3/16/17 DR

17.0120.01001
Title.02000

Adopted by the Human Services Committee

March 8, 2017

PROPOSED AMENDMENTS TO SENATE BILL NO. 2052

Page 2, line 19, remove "which is the same as the coverage for health services"

Page 2, line 20, remove "delivered by in-person means"

Renumber accordingly

Date: 3-8-17
Roll Call Vote #: 1

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB2052

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: 17.0120.01001

Recommendation: ☑ Adopt Amendment
☐ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☐ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Rohr Seconded By Rep. Skroch

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz			Rep. P. Anderson		
Vice Chairman Rohr			Rep. Schneider		
Rep. B. Anderson					
Rep. D. Anderson					
Rep. Damschen					
Rep. Devlin					
Rep. Kiefert					
Rep. McWilliams					
Rep. Porter					
Rep. Seibel					
Rep. Skroch					
Rep. Westlind					

Voice vote to accept the amendment. Motion carried

Total (Yes) _____ No _____

Absent _____

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 3-8-17
Roll Call Vote #: 2

2017 HOUSE STANDING COMMITTEE
ROLL CALL VOTES
BILL/RESOLUTION NO. SB 2052

House Human Services Committee

☐ Subcommittee

Amendment LC# or Description: _____

Recommendation: ☐ Adopt Amendment
☑ Do Pass ☐ Do Not Pass ☐ Without Committee Recommendation
☑ As Amended ☐ Rerefer to Appropriations
☐ Place on Consent Calendar

Other Actions: ☐ Reconsider ☐ _____

Motion Made By Rep. Skroch Seconded By Rep. Seibel

Representatives	Yes	No	Representatives	Yes	No
Chairman Weisz	✓		Rep. P. Anderson	✓	
Vice Chairman Rohr	✓		Rep. Schneider	✓	
Rep. B. Anderson	✓				
Rep. D. Anderson	✓				
Rep. Damschen	✓				
Rep. Devlin	✓				
Rep. Kiefert	✓				
Rep. McWilliams	✓				
Rep. Porter	✓				
Rep. Seibel	✓				
Rep. Skroch	✓				
Rep. Westlind	✓				

Total (Yes) 14 No 0

Absent 0

Floor Assignment Rep. D. Anderson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

SB 2052: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2052 was placed on the Sixth order on the calendar.

Page 2, line 19, remove "which is the same as the coverage for health services"

Page 2, line 20, remove "delivered by in-person means"

Renumber accordingly

2017 CONFERENCE COMMITTEE

SB 2052

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2052
4/5/2017
Job Number 29951

☐ Subcommittee
☒ Conference Committee

Committee Clerk Signature Marie Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage and retirement telehealth services.

Minutes: No attachments

Chair J. Lee: Brought the conference committee hearing to order, all members were present: Senator J. Lee, Senator Anderson, Senator Heckaman; Representative B. Anderson, Representative Kiefert, and Representative Schneider.

Representative B. Anderson: The main amendment we took off was the mandate for health insurance to cover.

Chair J. Lee: I understand that it is a contractual agreement, it also eliminates parity for face to face and telehealth appointments. Was that your intention?

Senator Anderson: When I saw this amendment, I thought the intention of the bill was to make the telehealth visit equivalent to a face to face visit. If you were going to have a telehealth visit, you had to have the same tests etc. Senator Lee tells me your intention was to allow insurance companies to pay less for a telehealth visit than they would for a face to face?

Representative B. Anderson: It's for them to be able to negotiate that.

Chair J. Lee: Would it be your expectation that it might be less?

Representative B. Anderson: I couldn't say one way or another.

Representative Kiefert: We heard in testimony from AARP that the state's average payout was $5500 per patient who uses telehealth; additionally, it shows a 25% reduction in bed days and19% reduction in hospital admission from patients using telehealth, so we're expecting there to be a significant difference in the cost of the services.

Chair J. Lee: I understand why telehealth will be an advantage, each specific telehealth consultation will be less for the insurers; because of coverage. But the reimbursement to the

individual providing the service is what we're talking about. They would get to keep the difference. We're talking about what they pay other people not what they get to keep. Senator Heckaman and Rep. B. Anderson provide same service, I'm a patient, because the telehealth person is faster, it means I'm not in the hospital as long, that doesn't mean you should be paid less because I'm hospitalized fewer days. That's different from the reimbursement out of the policy.

Senator Anderson: Did you hear from specific payers who thought they should be able to negotiate the prices separately, and pay less for the same service over telehealth, did you hear that from third party payers?

Representative B. Anderson: I don't believe so.

Representative Schneider: I don't recall the basis for that being different.

Chair J. Lee: Did you have any personal thoughts about parity versus negotiations on the reimbursements for individual providing telehealth or in person services?

Senator Anderson: What we hear from providers is that some of them would like to provide outreach services, we hear that from mental health people. What we don't want is for them to say, well I only get paid 1/2 if I do it over telehealth, so I'm not going to do it. If they provided the same service, they got the same pay. I understand that negotiations will be different, but across the board, providers and payers have supported telehealth services as an alternative. We do have some 3rd party payers here, we might ask them what they think.

Marnie Walth, Sanford Health: I testified neutral, I did make a point of talking about insurers needing to be able to negotiate rates, but did not ask for an amendment to be made, I'm guessing it was made accidentally, to accommodate what I was talking about, but from the Sanford Health standpoint, the original bill and the amended bill, neutral on both.

Chair J. Lee: So, it wasn't an amendment you had requested.

Representative Schneider: That's consistent with my notes.

Senator Anderson: If you negotiate a rate for a mental health visit of 30 minutes, you would negotiate same rate whether it would be face to face vs telehealth.

Megan Houn, Blue Cross Blue Shield: I'm not a negotiations person either, relative to access, part of the heart burn we've had about payment parity in the bill, BCBS has been reimbursing telehealth for 15 years, and letting the market dictate the rates, we can actually reimburse telehealth at a higher rate than an in person visit if demand is higher. But if you lock everybody in, it's different. Typically, we don't see a lower negotiate rate, you see a parity rate regardless, where you might see a lower negotiated rate was last session, cash and carry, where you don't bill health insurance. If you pay $50 for a visit on your IPhone that doesn't come through insurance, so that might be a lower rate. When insurance is billed for reimbursement, that's often parity or higher; locking us in at parity can hurt.

Senator Anderson: My original understanding was to have the same care. I've been told that it's for payment parity.

Megan Houn: We didn't ask for this amendment either. The original bill that went through PERS did not have payment parity, it left it to the contract negotiations between the insurers and the providers. I think payment parity isn't something we'd like to see, but equal standard of care would be correct, the Board of Medicine has gone through some significant rule making, they have set forth some rules, having to have implements for telehealth if needed in face to face. Their caveat was deferring to the physician's expertise.

Senator Anderson: That was what my perception of that original language was to try and match what the Medical Board is doing with their telehealth rules, that was my intention; I never thought about pay.

Courtney Kobele, NDMA: I can tell you they were developing administrative rules, whatever you can do in person, if you can do it by telehealth, then fine, but it has to be equal.

Chair J. Lee: I know there have been examples of a specialist, there would be medical professional in the room to use the instruments and runs the tests.

Courtney Kobele: To offer my 2 cents, we supported it last session, we support it this session; it was a tad puzzling about that, if you look at bill, it's on section 2, but it talks about it in section 3, the Medical Association prefer the original.

Maureen Ideker, RN Telehealth, Essentia Health: The PERS 2-year trial went well. Essentia Health and North Dakota Health Information Network support the original bill, we don't support the amendment, it takes away any need to have parity at all. It says in North Dakota perhaps the rehab therapist, who would be paid in person, wouldn't be paid if they were doing it by telehealth. Gave examples.

Senator Anderson: Why wouldn't they be covered?

Maureen Ideker: The insurance companies don't cover it now, and won't if they don't have to. Part of the telehealth parity bill says that the health professionals that are covered in person would also be covered by telehealth. It would allow the rehab therapist etc. to be covered. It would be up to the insurance company to decide if they were going to cover or not. The parity bill has to do with equalizing that, so that people in rural areas can access those services. It's important to not have that amendment. There was nothing about this in the last meeting; not only did Sanford Health say they were neutral, there was no recommendation to have that struck out.

Chair J. Lee: Sparb was here from PERS, he recommends to continue for general population, I don't recall him having comment about this. Is there anybody who has a recommendation about PERS? Tell me what PERS has covered.

Sharon Schiermeister, Chief Operating Officer, NDPERS: Regarding the amendment we didn't recommend it, we have no position on that.

Chair J. Lee: In the 2 years that PERS did telehealth, what coverage did it provide? Are those kinds of thing covered in PERS or not?

Sharon Schiermeister: I'll defer.

Marsha Waind, Altru Health System: We provide 5,000 visits of covered telehealth services per year. Under NDPERS, they utilized the Sanford Health Plan policy statement. As a provider of service, we asked them: Would you expand that coverage? They provided the policy of the Sanford Health Plan. Gave an example with childhood asthma.

Chair J. Lee: There is not parity in the PERS policy the last two years. So we would be expanding coverage.

Marsha Waind: You would be expanding to what their insurance coverage pays for in person. That's how I understand this language: If it's covered in person it should it be covered under telehealth. The practice boards are responsible for monitoring the practice of service of their licensees.

Tim Blasl, NDHA: I don't have much to add, just visiting with our members, we support the original bill with the coverage parity.

Megan Houn: I did some checking, on our side, if it's covered in person, it's covered in telehealth, eg. diabetes education, approved on both sides. The expansion of services in the bill as it's written does include naturopaths, which is not somebody that we reimburse, it does allow audio only, which we don't reimburse for.

Marnie Walth, Sanford Health: When I prepared testimony, I asked Lisa Carlson when PERS passed requirement if anything changed, she said no, we were already covering the things that were happening for patients.

Chair J. Lee: With the new input, if you'd follow up on questions, I would love it if you'd talk it over.

Senator Heckaman: I'm looking to see where naturopaths are covered, I'm not finding it.

Gallery: 1c.

Chair J. Lee: I get the audio part too. Have an informal conversation, help us streamline the process.

Chair J. Lee: Meeting is adjourned.

2017 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Red River Room, State Capitol

SB 2052
4/10/2017
Job Number 30008

☐ Subcommittee
☒ Conference Committee

Committee Clerk Signature Marne Johnson

Explanation or reason for introduction of bill/resolution:

A bill relating to health insurance coverage and retirement telehealth services.

Minutes: No attachments

Chair J. Lee: Brought the conference committee hearing to order. All members were present: Senator Lee, Senator Anderson, Senator Heckaman; Representative Bert Anderson, Representative Weisz, and Representative Schneider.

Senator Heckaman: Rep. Weisz, can you vote in Rep. Kiefert's place?

Representative Weisz: Yes, the floor session this morning replaced him with me.

Chair J. Lee: After the discussion last time, I asked the stakeholders to meet, they came back and decided they prefer the original version. That's where we left it.

Representative Bert Anderson: I move to recede from House amendments.
Senator Anderson: Second
A roll call vote was taken.
Motion passes 6-0-0.
Senator Heckaman and Representative Bert Anderson will carry.
Chair J. Lee: Closed the hearing.

Date: 4/10/17
Roll Call Vote #: 1

2017 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. 2052 as (re) engrossed

Senate "Enter committee name" Committee

Action Taken
- ☐ **SENATE accede to House Amendments**
- ☐ **SENATE accede to House Amendments and further amend**
- ☒ **HOUSE recede from House amendments**
- ☐ **HOUSE recede from House amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Rep. Anderson Seconded by: Sen Anderson

Senators	4/5	4/10		Yes	No	Representatives	4/5	4/10		Yes	No
Senator J. Lee	X	X		X		Rep. B. Anderson	X	X		X	
Senator H. Anderson	X	X		X		Rep. Kiefert	X				
Senator Heckaman	X	X		X		Rep Schneider	X	X		X	
						Rep Weisz		X		X	
Total Senate Vote						Total Rep. Vote					

Vote Count Yes: 6 No: 0 Absent: 0

Senate Carrier Sen. Heckaman House Carrier Rep. Anderson

LC Number _____ . _____ of amendment

LC Number _____ . _____ of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

REPORT OF CONFERENCE COMMITTEE

SB 2052: Your conference committee (Sens. J. Lee, Anderson, Heckaman and Reps. B. Anderson, Weisz, Schneider) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ page 770 and place SB 2052 on the Seventh order.

SB 2052 was placed on the Seventh order of business on the calendar.

2017 TESTIMONY

SB 2052

SB2052 Attach #1
1/9

TESTIMONY OF NDPERS

SENATE BILL 2052

Madam Chair, members of the committee my name is Sparb Collins. I am the Executive Director of the North Dakota Public Employees Retirement System (NDPERS). I appear before you today on behalf of the PERS Board and in support of this bill. Last Legislative Session this bill passed as HB 1038 and pursuant to NDCC 54-03-28 (2) (b):

> *The application of the mandate is limited to the public employee's 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*

In compliance with this section this coverage was a part of the PERS health plan for 2015-17. Please note that the PERS health plan had been providing this service to our membership before the passage of the bill and therefor this requirement did not have an actuarial effect on the plan during the 205-17 biennium. The bill before you today, Senate Bill 2052, is submitted by PERS pursuant to NDCC Section 54-03-28 (2) (c) which states:

> *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.*

As noted this section requires PERS to:

1. *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 bill before you today is in response to that requirement.

2. 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.

3. The report must include a recommendation on whether the coverage or payment should continue

Concerning the second requirement attached to my testimony is the information that was reviewed by the PERS board. The following is:

a) Pages A-1 to A-5 is a review of the bill does by the PERS health plan consultant which is Deloitte Consulting firm.
b) Pages A6- A20 Is a national paper done by the Deloitte Consulting firm on telehealth.
c) A 21- to A 25 is PERS specific telehealth data compiled by Sanford Health plan.

Concerning requirement #3 above "the report must include a recommendation on whether the coverage or payment should continue" you will note that on page A-5 of the Deloitte report they state:

> *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*

At the October meeting of the PERS Board after reviewing the attached information the Board moved to support this bill and telehealth services for its members.

In addition to the PERS Boards review of this bill the Legislative Employee Benefits Committee also reviewed the information. All bills relating to PERS must be submitted to them for review during the interim. Pursuant to this legislative direction the bill was submitted to that committee. After there review they gave the bill a "favorable recommendation".

Madame Chair, this concludes my testimony.

SB 2052
Attach # 1A
1/9

Deloitte.

Deloitte Consulting LLP
50 South Sixth Street
Ste 2800
Minneapolis, MN 55402
USA

Tel: 7979709790
Fax: 97970979
www.deloitte.com

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 COVARAGE 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.[1] Some recent studies show that*

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Professional Services means audit, tax, consulting, and advisory.

telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,[2] while others are concerned about its potential to increase costs in a fee-for-service environment.[3] 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.[4]

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.[5] 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[6] 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

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

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[1].
- 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[2].
- Heart failure patients participating in a telemonitoring study had 12% lower total costs[3].
- 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[4].
- 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[5].

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[1] 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).

[2] 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.

[3] 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).

[4] 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.

[5] 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).

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.

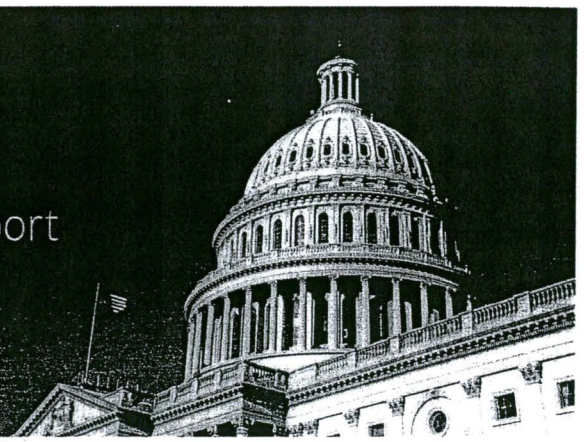
Due to positive results of research and analysis into the effectiveness and potential for cost savings, Deloitte recommends that NDPERS continue coverage of appropriate telehealth services.

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.[1] Some recent studies show that telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,[2] while others are concerned about its potential to increase costs in a fee-for-service (FFS) environment.[3] 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.[4]

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.[5] 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[6] in states and Medicaid managed care
- State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations

ed in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries. Certain services may not be available to attest clients under the rules and regulations of public accounting.

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.[7] 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.[8] 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.[9] 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.[10]

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.[11]

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.[12]

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.

A-7

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.[13]

As accountable care organizations (ACOs) and other [illegible]ue-based care (VBC) models increase, CMS is [illegible]rimenting 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.[14] 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.[15] 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.[16]

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.[17] 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,[18] 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.[19]

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.[20] 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.[21]

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.[22] 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.[23]

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.[24] 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.[26] MA plans can choose to pay for and provide telehealth services more broadly—as extra benefits—than Medicare FFS.[27] MA plans finance these benefits through their rebate dollars or by charging beneficiaries a supplemental premium.[28] Despite these flexibilities, most MA plans follow the standard Medicare originating site rule.

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

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.[25] 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+	The risk-based primary care initiative aims to accelerate the shift toward value-based reimbursement and emphasizes health IT and chronic care management. 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.[32]	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. Providers may decide to use the incentive payments to invest in telehealth.[33]
ACO Next Generation	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.[34]	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). 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).[35]
CCJR	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.[36]	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).
BPCI	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 responsilbity for episodes of care triggered by a hospital admission.[37]	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.

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.[38] 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, [illegible]avioral health and dental care, as well as hospital [illegible]. The rule includes factors states should consider [illegible]tting standards, including the use of telemedicine, [illegible]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.[39] 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.[40]

"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
Medicaid reimbursement	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.	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. 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.
Private insurance parity	Twenty eight states and DC have laws requiring private insurers to reimburse telehealth services at the same rate as in-person services. 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.	Most states self-insure their state employee health plans, meaning that they would be exempt under traditional private insurer parity requirements. 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.[41]
Licensing and reciprocity	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.[42] Medical provider licensing can limit telehealth programs.[43]	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. Representatives from telehealth groups and the Texas Medical board have been meeting to see if compromise language can be established. Talks are ongoing.[44]

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

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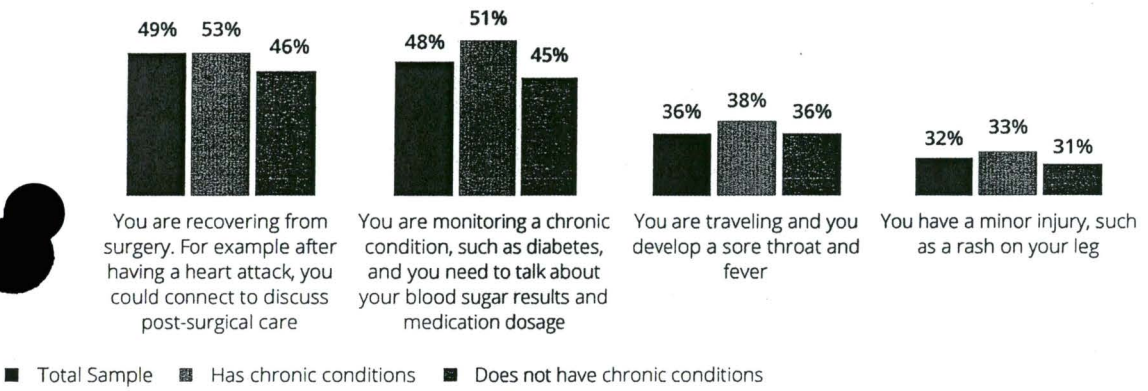
Consumer attitudes about telehealth

Deloitte's *2016 Survey of US Health Care Consumers*[45] 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).

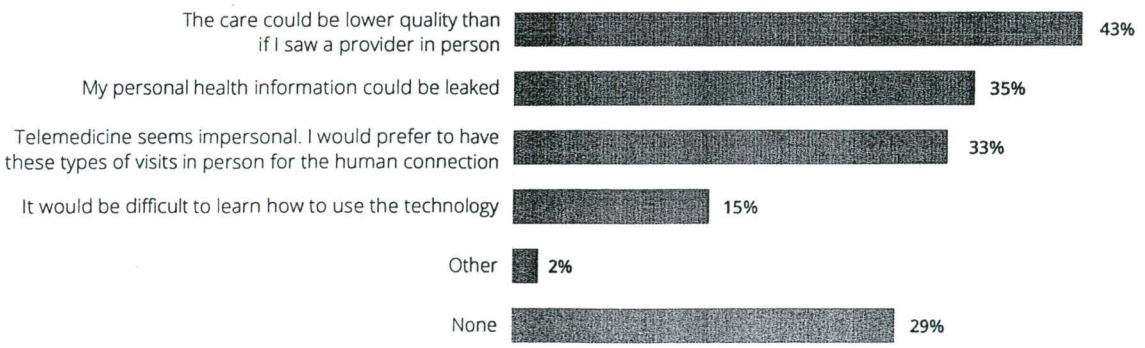
These trends indicate that, similar to banking and retail, health care is not exempt from consumer demand for technology to makes services and information easier to access.

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 polices 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.[46]

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.[47] 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.[48]

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.[49]

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 Tahir, "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.[50]

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.

A-15

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.

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Authors

Harry Greenspun
Managing Director
Deloitte Services LP
hgreenspun@deloitte.com

Casey Korba
Health Policy Manager
Deloitte Center for Health Solutions
Deloitte Services LP
ckorba@deloitte.com

Arielle Kane
Senior Business Project Specialist
Deloitte Center for Health Solutions
Deloitte Services LP
arkane@deloitte.com

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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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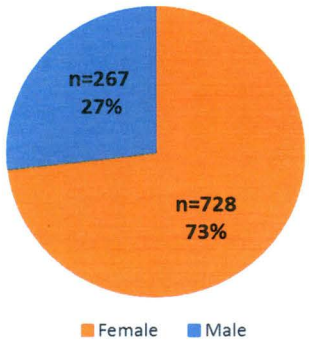
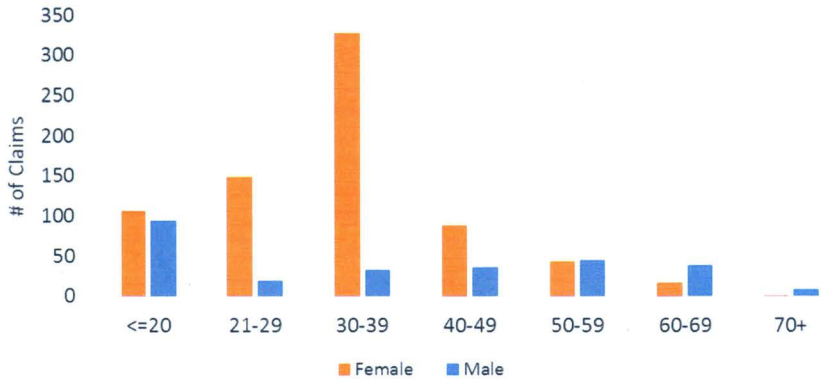
NDPERS Telehealth Summary

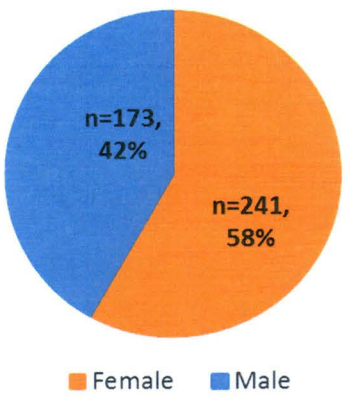
Claims incurred between 7/1/15 and 6/30/16, paid through 8/9/16

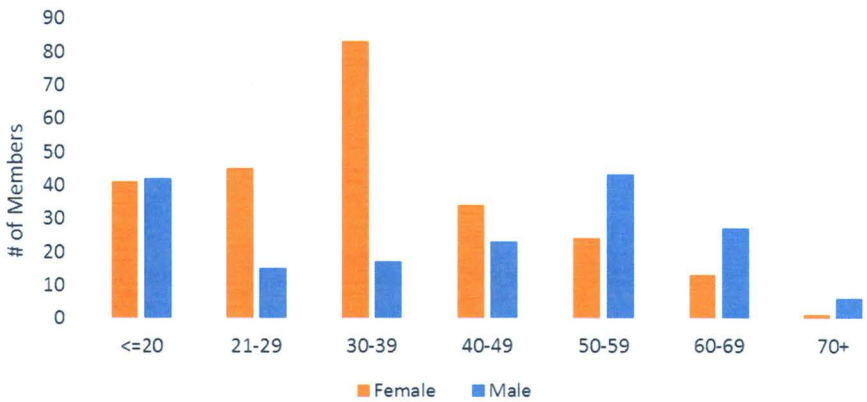
Total Telehealth Claims by Gender and Age Bands





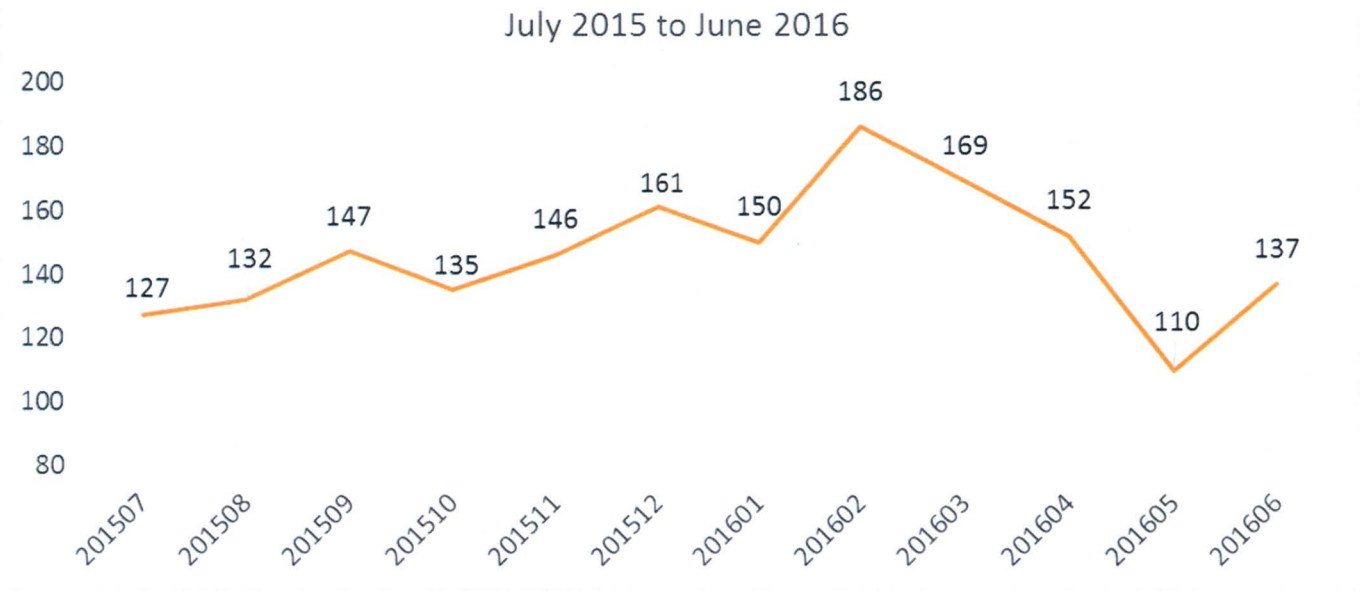
Total Telehealth Members by Gender and Age Bands





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

	Member State			
Provider State	**MN**	**ND**	**SD**	**Grand Total**
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
Grand Total	**28**	**991**	**3**	**1022**

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										
	⊟ND								⊞MN	⊞SD	Grand Total
Provider City	GRAND FORKS	BISMARCK	WILLISTON	JAMESTOWN	MINOT	DEVILS LAKE	DICKINSON	Other ND			
⊟ND											
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
⊞MN	2	2	1	10		5	4	62	12		98
⊞IL	12							11	2		25
⊞MT			22		1			2			25
⊞SD		5		2				8	3	3	21
⊞NE					8						8
⊞WA								4			4
⊞FL		1									1
⊞IA									1		1
⊞ID		1									1
⊞NULL						18		10			28
Grand Total	169	117	83	72	64	54	49	384	28	3	1023

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
Grand Total	**874**	**$187,477**

Excludes CPT code 'Q3014'

Claims by Provider Group

Top 15 Provider Groups by Total Charged. There 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
Grand Total	**1,526**	**$221,524**

Claims by Diagnosis

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

Diag 1	Diagnosis Description	Claims	Total Charged
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
	Grand Total	**431**	**$94,627**

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

Excludes CPT code 'Q3014'

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

TESTIMONY TO:

SENATE HUMAN SERVICES COMMITTEE

65TH NORTH DAKOTA LEGISLATIVE ASSEMBLY

Senate Bill 2052 1/9/2017

Madam Chairman Senator Lee and Committee Members:

I am Cheryl Rising, Family Nurse Practitioner (FNP) and Legislative Liaison for the North Dakota Nurse Practitioner Association (NDNPA). I am here to testify in support of Senate Bill 2052, relating to individual and group health insurance coverage of telehealth services.

NDNPA supports the definition of Health Care Provider lines 16 through 19 and the bill as written. Numerous APRN's already participate in Telehealth. Telehealth has been utilized by psychiatric nurse practitioners, nurse practitioners practicing in dermatology, and long term care to name a few. We also support store-and – forward technology. Dermatology is an area that will utilize the store-and-forward technology. I have testimony attached from an Advance Practice Registered Nurse in dermatology working in rural ND and MN.

This concludes my testimony and I entertain any questions.

Cheryl Rising, RN, MS, FNP-BC

701-527-2583

crisingnp@gmail.com

SB 2052 Attach # 3
1/9

January 9th, 2017

To Senate Human Services committee 65th North Dakota Legislative Assembly
by Jennifer Tinkler, FNP
701-740-0052
jtinkler@live.com

Madame Chairman, Senator Lee and Committee Members,

I am Jennifer Tinkler, FNP licensed in both North Dakota and Minnesota. I am writing to support Senate bill 2052 including store and forward technology for telehealth. I have provided video telehealth at multiple sites in North Dakota for approximately 10 years. I believe the cost of video telehealth exceeds the cost of store and forward technology due to both the cost of video cameras to rural sites as well as the need for patients to travel to the outreach site the video is available at. In my experience with telehealth at 13 rural clinic sites, store and forward technology is critically important as a means to access care. Store and forward teleheatlh will increase access to specialties that have a shortage of providers. It not only reduces cost, it s more accessible to patients by eliminating the need to travel to a site with video equipment. Store and forward telehealth also provides higher quality images than video. Store and forward technology is important for specialties like dermatology that require clear images to make a diagnosis. Often video telehealth equipment is shared by multiple specialties and not available when needed. The credentialing process to provide video telehealth also requires credentialing many providers at many sites and could be eliminated by store and forward technology. It is my opinion that store and forward telehealth removes many barriers to accessing care. I believe that accessing care through store and forward telehealth as a primary way to access the health system will decrease wait time for video availability, commute time to available sites, and lastly cost of care. Video telehealth has continued barriers in that it requires staffing multiple sites where there may also be a workforce shortage, coordinating multiple specialties utilizing the camera and only provides access to those few that are credentialed at the rural site. Continued limited access to video technology means the barrier of travel in many rural areas still exists. In my experience, I would utilize store and forward technology as a primary means of providing health care to rural areas and view it as a means of reducing the cost of care, increasing access and reducing commute time for patients.

Jennifer Tinkler, FNP

SB 2052 Attach #.4
1/9

Senate Human Services Committee
Testimony Regarding SB 2052
January 9, 2017

Chairwoman Lee and members of the Senate Human Services Committee:

On behalf of the North Dakota Telehealth Domain Task Force of the North Dakota Health Information Network, thank you for this opportunity to comment on SB 2052. The Telehealth Domain Task Force represents 40 rural and urban hospitals, nursing homes and clinic settings, licensed health care professionals, and public and private health care related agencies across North Dakota.

The Task Force supports SB 2052 and joins the Employee Benefits Programs Committee in recommending the passage of SB 2052 as introduced.

Currently, existing telehealth coverage and eligibility guidelines of North Dakota insurers are patterned after Medicare guidelines, which in our opinion are overly restrictive and limit the access of many North Dakotans to the various benefits of telehealth. As a result, the Task Force believes the passage of SB 2052 is vital to achieve telehealth parity so as to allow healthcare providers to fully utilize the numerous benefits of telehealth and ensure that consumers have equal access to efficient and effective healthcare services throughout North Dakota. In 2016, at the request of the Employee Benefits Programs Committee, the consulting firm Deloitte conducted a review of SB 2052 in which it detailed the positive results and impacts of telehealth in the areas of cost savings and achieving value-based, patient-centered care.

In addition to the benefits identified by the Deloitte study, the Task Force believes SB 2052 would have the following impacts:

- It lifts the restriction on urban settings as eligible sites, which allows healthcare settings in the urban area to share licensed providers across settings or bring in non-existent sub-specialists to stretch scarce resources using technology, gain efficiencies, and avoid transfers.
- It provides a broader definition of licensed health care professional eligible for reimbursement, including: audiologists, pharmacists, genetic counselors, RN certified diabetic educators, physical and occupational therapists, speech language pathologists, dentists, optometrists, and chiropractors. The inclusion of these additional professions would not only allow for access to services throughout North Dakota, but would also reduce the distance patients must travel to access healthcare services.
- It expands the definition of originating site to include group homes, assisted living facilities, and individual homes as sites where patients can receive these services and providers would be eligible for reimbursement. Currently, telehealth services are not available to the developmentally disabled living in group homes, behavioral health residents of group homes, or the elderly in assisted living facilities. Allowing group homes and assisted living facilities to be eligible sites for service would reduce expensive transfer costs and decrease unnecessary admissions to emergency rooms, especially after daytime hours.

SB 2052
Attach.
#4

Again, in light of the many benefits of fully utilizing telehealth in the delivery of healthcare services throughout North Dakota, the Task Force strongly supports the passage of SB 2052.

Respectfully submitted by the North Dakota Telehealth Domain Task Force Co-Chairs,

Maureen Ideker R.N.

Maureen Ideker RN, BSN, MBA
System Director of Telehealth
Essentia Health
maureen.idekder@essentiahealth.org

Marsha Waind MOTR-L
Manager Telehealth
Altru Health System
mawaind@altru.org

SANFORD HEALTH

SB 2052 Attach # 5
1/9

Senate Human Services Committee
Sen. Judy Lee, Chair
Jan. 9, 2017

Chairman Lee and members of the Committee: My name is Marnie Walth and I represent Sanford Health. Thank you for the opportunity to share thoughts on SB2052.

For rural states like North Dakota where workforce is stretched thin and demand outpaces supply, telemedicine is emerging as a convenient, cost-effective alternative to traditional face-to-face consultations and examinations. Sanford Health increasingly employs telemedicine to improve access to services and reduce patients' costs associated with long-distance travel.

That said, Sanford Health is neutral on SB2052 in that we believe the bill's intent to legislate coverage requirements and use of the technology is not necessary. The health insurance market already recognizes and supports an increasingly robust demand for telemedicine technology (all major health plans in North Dakota already pay for telemedicine services); and the N.D. Board of Medicine has policies in place that dictate how and when medical providers may employ telemedicine and for which services.

If the bill moves forward, Sanford Health strongly encourages keeping in place the language that prohibits interfering with insurer-provider negotiations. Telemedicine technology is advancing quickly and so avoiding barriers that may constrain innovation or drive up costs by dictating provider reimbursement rates is critical. As an example, requiring parity payment for a pinkeye diagnoses when a telehealth visit may cost $50, a clinic visit $200 and a trip to the emergency room $600, would drive costs up rather than down.

Thank you for your time. I would be happy to answer any questions you might have.

Marnie Walth
marnie.walth@sanfordhealth.org
701-323-8745

Att. 1

House Human Services Committee
SB 2052 Testimony
March 7, 2017
NDPERS

Fort Union Room

Att. 1
SB 2052
3-7-17

TESTIMONY OF NDPERS

SENATE BILL 2052

Mr. Chairman, members of the committee my name is Sharon Schiermeister. I am the Chief Operating Officer for the North Dakota Public Employees Retirement System (NDPERS). I appear before you today on behalf of the PERS Board and in support of this bill. Last Legislative Session this bill passed as HB 1038 and provided that pursuant to NDCC 54-03-28 (2) (b):

> *The application of the mandate is limited to the public employee's 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*

In compliance with this section this coverage was a part of the PERS health plan for 2015-17. Please note that the PERS health plan had been providing this service to our membership before the passage of the bill and therefor this requirement did not have an actuarial effect on the plan during the 2015-17 biennium. The bill before you today, Senate Bill 2052, is submitted by PERS pursuant to NDCC Section 54-03-28 (2) (c) which states:

> *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.*

As noted this section requires PERS to:

1. *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 bill before you today is in response to that requirement.
2. 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.

3. The report must include a recommendation on whether the coverage or payment should continue

Concerning the second requirement attached to my testimony is the information that was reviewed by the PERS board. The following is:

a) Pages A-1 to A-5 is a review of what the bill does by the PERS health plan consultant which is Deloitte Consulting firm.
b) Pages A6- A20 Is a national paper done by the Deloitte Consulting firm on telehealth.
c) A 21- to A 25 is PERS specific telehealth data compiled by Sanford Health plan.

Concerning requirement #3 above "the report must include a recommendation on whether the coverage or payment should continue" you will note that on page A-5 of the Deloitte report they state:

> *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*

At the October 2016 meeting of the PERS Board after reviewing the attached information the Board moved to support this bill and telehealth services for its members.

In addition to the PERS Boards review of this bill the Legislative Employee Benefits Committee also reviewed the information. All bills relating to PERS must be submitted to them for review during the interim. Pursuant to this legislative direction the bill was submitted to that committee. After their review they gave the bill a "favorable recommendation".

Mr. Chairman, this concludes my testimony.

Deloitte Consulting LLP
50 South Sixth Street
Ste 2800
Minneapolis, MN 55402
USA

Tel: 7979709790
Fax: 97970979
www.deloitte.com

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 COVARAGE 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.[1] 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,[2] while others are concerned about its potential to increase costs in a fee-for-service environment.[3] 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.[4]

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.[5] 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[6] 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

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

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[1].
- 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[2].
- Heart failure patients participating in a telemonitoring study had 12% lower total costs[3].
- 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[4].
- 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[5].

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[1] 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).

[2] 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.

[3] 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).

[4] 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.

[5] 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).

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.

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.[1] Some recent studies show that telehealth visits are associated with lower costs than traditional in-office visits and could result in Medicare savings,[2] while others are concerned about its potential to increase costs in a fee-for-service (FFS) environment.[3] 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.[4]

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.[5] 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[6] in states and Medicaid managed care
- State policy trends, including licensing reciprocity and reimbursement, and examples of state telehealth regulations

As used in this document, "Deloitte" means Deloitte LLP and its subsidiaries. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries. Certain services may not be available to attest clients under the rules and regulations of public accounting.

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.[7] 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.[8] 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.[9] 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.[10]

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.[11]

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.[12]

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.[13]

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.[13]

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.[14] 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.[15] 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.[16]

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.[17] 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,[18] 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.[19]

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.[20] 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.[21]

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.[22] 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.[23]

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.[24] 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.[26] MA plans can choose to pay for and provide telehealth services more broadly—as extra benefits—than Medicare FFS.[27] MA plans finance these benefits through their rebate dollars or by charging beneficiaries a supplemental premium.[28] 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.[29] Humana announced in early 2016 that it would offer some telehealth services to its MA beneficiaries, as well.[30] Finally, the Senate Finance Committee is examining telehealth in MA through its work on chronic care management legislation.[31]

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.[25] 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+	The risk-based primary care initiative aims to accelerate the shift toward value-based reimbursement and emphasizes health IT and chronic care management. 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.[32]	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. Providers may decide to use the incentive payments to invest in telehealth.[33]
ACO Next Generation	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.[34]	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). 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).[35]
CCJR	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.[36]	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).
BPCI	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 responsilbity for episodes of care triggered by a hospital admission.[37]	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.

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.[38] 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.[39] 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.[40]

"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
Medicaid reimbursement	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.	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. 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.
Private insurance parity	Twenty eight states and DC have laws requiring private insurers to reimburse telehealth services at the same rate as in-person services. 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.	Most states self-insure their state employee health plans, meaning that they would be exempt under traditional private insurer parity requirements. 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.[41]
Licensing and reciprocity	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.[42] Medical provider licensing can limit telehealth programs.[43]	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. Representatives from telehealth groups and the Texas Medical board have been meeting to see if compromise language can be established. Talks are ongoing.[44]

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

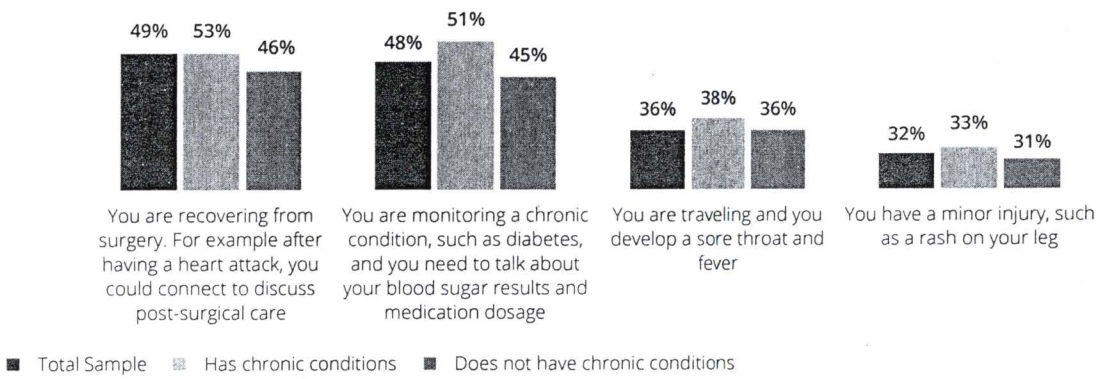
Consumer attitudes about telehealth

Deloitte's *2016 Survey of US Health Care Consumers*[45] 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).

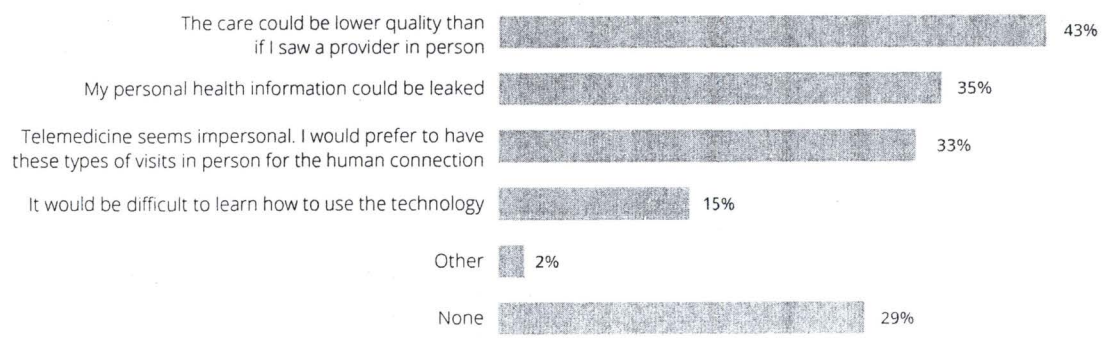
These trends indicate that, similar to banking and retail, health care is not exempt from consumer demand for technology to makes services and information easier to access.

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 polices 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.[46]

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.[47] 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.[48]

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.[49]

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 Tahir, "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.[50]

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.

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Authors

Harry Greenspun
Managing Director
Deloitte Services LP
hgreenspun@deloitte.com

Casey Korba
Health Policy Manager
Deloitte Center for Health Solutions
Deloitte Services LP
ckorba@deloitte.com

Arielle Kane
Senior Business Project Specialist
Deloitte Center for Health Solutions
Deloitte Services LP
arkane@deloitte.com

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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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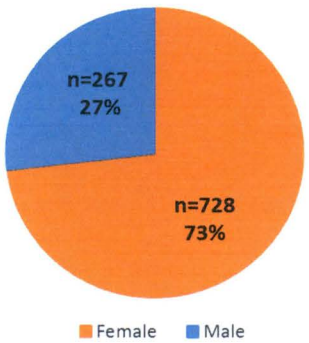
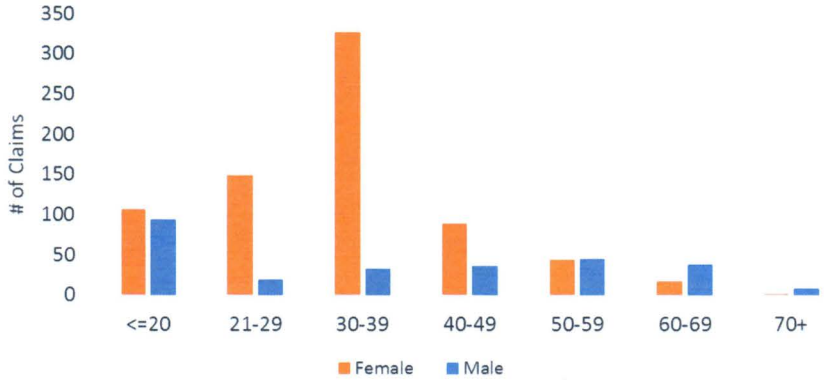
NDPERS Telehealth Summary

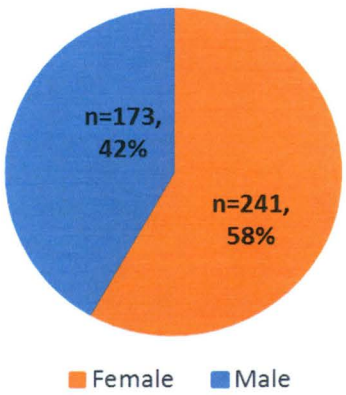
Claims incurred between 7/1/15 and 6/30/16, paid through 8/9/16

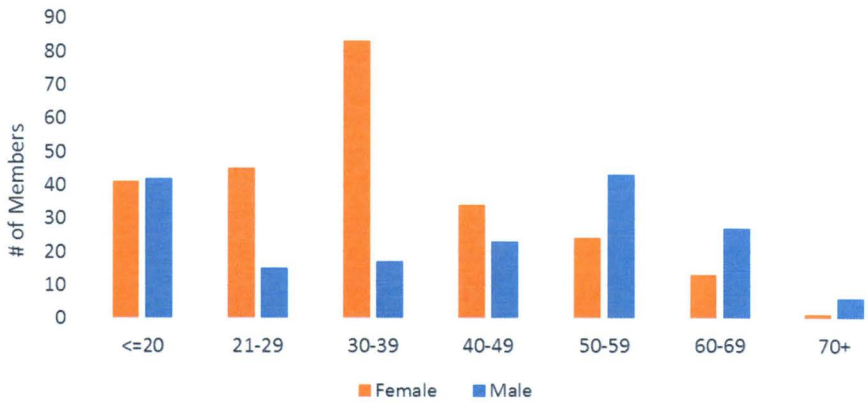
Total Telehealth Claims by Gender and Age Bands





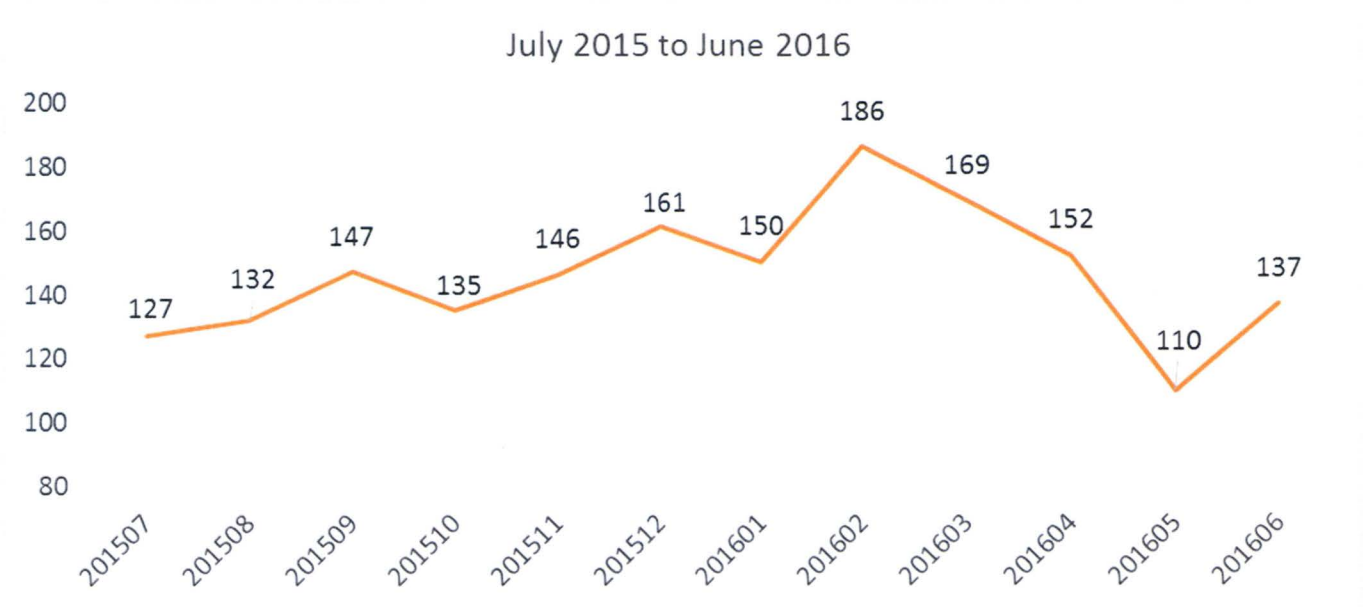
Total Telehealth Members by Gender and Age Bands





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

	Member State			
Provider State	**MN**	**ND**	**SD**	**Grand Total**
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
Grand Total	**28**	**991**	**3**	**1022**

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										
	⊟ND								⊞MN	⊞SD	Grand Total
Provider City	GRAND FORKS	BISMARCK	WILLISTON	JAMESTOWN	MINOT	DEVILS LAKE	DICKINSON	Other ND			
⊟ND											
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
⊞MN	2	2	1	10		5	4	62	12		98
⊞IL	12							11	2		25
⊞MT			22		1			2			25
⊞SD		5		2				8	3	3	21
⊞NE					8						8
⊞WA								4			4
⊞FL		1									1
⊞IA									1		1
⊞ID		1									1
⊞NULL						18		10			28
Grand Total	169	117	83	72	64	54	49	384	28	3	1023

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
Grand Total	**874**	**$187,477**

Excludes CPT code 'Q3014'

Claims by Provider Group

Top 15 Provider Groups by Total Charged. There 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
Grand Total	**1,526**	**$221,524**

Claims by Diagnosis

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

Diag 1	Diagnosis Description	Claims	Total Charged
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
	Grand Total	**431**	**$94,627**

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

Excludes CPT code 'Q3014'

Att. 2
S.B. 2052
3-7-17

House Human Services Committee
Testimony Regarding SB 2052
March 7, 2017

Chairman Weis and members of the House Human Services Committee:

On behalf of the North Dakota Telehealth Domain Task Force of the North Dakota Health Information Network, thank you for this opportunity to comment on SB 2052. The Telehealth Domain Task Force represents 40 rural and urban hospitals, nursing homes and clinic settings, licensed health care professionals, and public and private health care related agencies across North Dakota.

The Task Force supports SB 2052 and joins the Employee Benefits Programs Committee in recommending the passage of SB 2052 as introduced.

Currently, existing telehealth coverage and eligibility guidelines of North Dakota insurers are patterned after Medicare guidelines, which in our opinion are overly restrictive and limit the access of many North Dakotans to the various benefits of telehealth. As a result, the Task Force believes the passage of SB 2052 is vital to achieve telehealth parity so as to allow healthcare providers to fully utilize the numerous benefits of telehealth and ensure that consumers have equal access to efficient and effective healthcare services throughout North Dakota. In 2016, at the request of the Employee Benefits Programs Committee, the consulting firm Deloitte conducted a review of SB 2052 in which it detailed the positive results and impacts of telehealth in the areas of cost savings and achieving value-based, patient-centered care.

In addition to the benefits identified by the Deloitte study, the Task Force believes SB 2052 would have the following impacts:

- **Lifts Urban Site Restriction**
  It lifts restrictions on urban settings as eligible sites, which allows healthcare settings in the urban area to share licensed providers across settings or bring in non-existent sub-specialists to stretch scarce resources using technology, gain efficiencies, and avoid transfers.

- **Broadens definition of eligible ND healthcare providers**
  It provides a broader definition of licensed healthcare professionals eligible for reimbursement, including: audiologists, pharmacists, genetic counselors, RN certified diabetic educators, physical and occupational therapists, speech language pathologists, dentists, optometrists, and chiropractors. The inclusion of these additional professions would not only allow for access to services throughout North Dakota, but would also reduce the distance patients must travel to access healthcare services.

- **Originating sites eligible for patients expanded**

It expands the definition of originating site for patients to include group homes, assisted living facilities, and individual homes as sites where patients can receive these services and providers would be eligible for reimbursement. Currently, telehealth services are not available to the developmentally disabled living in group homes, behavioral health residents of group homes, or the elderly in assisted living facilities. Allowing group homes and assisted living facilities to be eligible sites for service would reduce expensive transfer costs and decrease unnecessary admissions to emergency rooms, especially after daytime hours.

Again, in light of the many benefits of fully utilizing telehealth in the delivery of healthcare services throughout North Dakota, the Task Force strongly supports the passage of SB 2052.

Respectfully submitted by the North Dakota Telehealth Domain Task Force Co-Chairs,

Maureen Ideker R.N.

Maureen Ideker RN, BSN, MBA
System Director of Telehealth
Essentia Health
maureen.idekder@essentiahealth.org

Marsha Waind MOTR-L
Manager Telehealth
Altru Health System
mawaind@altru.org

att. 3
S.B 2052
3-7-17

NDNPA
NORTH DAKOTA
Nurse Practitioner Association

TESTIMONY TO:

HOUSE HUMAN SERVICES COMMITTEE

65TH NORTH DAKOTA LEGISLATIVE ASSEMBLY

Senate Bill 2052 3/7/2017

Chairman Weisz and Committee Members,

I am Cheryl Rising, Family Nurse Practitioner (FNP) and Legislative Liaison for the North Dakota Nurse Practitioner Association (NDNPA). I am here to testify in support of Senate Bill 2052, relating to individual and group health insurance coverage of telehealth services.

NDNPA supports the definition of Health Care Provider lines 16 through 19 page one and the bill as written. Numerous APRN's already participate in Telehealth. Telehealth has been utilized by psychiatric nurse practitioners, nurse practitioners practicing in dermatology, and long term care to name a few. We also support store-and –forward technology. Dermatology is an area that will utilize the store-and-forward technology. I have testimony attached from an Advance Practice Registered Nurse in dermatology working in rural ND and MN.

This concludes my testimony and I entertain any questions.

Cheryl Rising, RN, MS, FNP-BC

701-527-2583

crisingnp@gmail.com

Att. 4 3/7/17
SB 2052

March 6, 2017

To House Human Services committee

by Jennifer Tinkler, FNP

701-740-0052

jtinkler@live.com

Chairman Weisz and committee Members,

I am Jennifer Tinkler, FNP licensed in both North Dakota and Minnesota. I am writing to support Senate bill 2052 including store and forward technology for telehealth. I have provided video telehealth at multiple sites in North Dakota for approximately 10 years. I believe the cost of video telehealth exceeds the cost of store and forward technology due to both the cost of video cameras to rural sites as well as the need for patients to travel to the outreach site the video is available at. In my experience with telehealth at 13 rural clinic sites, store and forward technology is critically important as a means to access care. Store and forward teleheatlh will increase access to specialties that have a shortage of providers. It not only reduces cost, it s more accessible to patients by eliminating the need to travel to a site with video equipment. Store and forward telehealth also provides higher quality images than video. Store and forward technology is important for specialties like dermatology that require clear images to make a diagnosis. Often video telehealth equipment is shared by multiple specialties and not available when needed. The credentialing process to provide video telehealth also requires credentialing many providers at many sites and could be eliminated by store and forward technology. It is my opinion that store and forward telehealth removes many barriers to accessing care. I believe that accessing care through store and forward telehealth as a primary way to access the health system will decrease wait time for video availability, commute time to available sites, and lastly cost of care. Video telehealth has continued barriers in that it requires staffing multiple sites where there may also be a workforce shortage, coordinating multiple specialties utilizing the camera and only provides access to those few that are credentialed at the rural site. Continued limited access to video technology means the barrier of travel in many rural areas still

exists. In my experience, I would utilize store and forward technology as a primary means of providing health care to rural areas and view it as a means of reducing the cost of care, increasing access and reducing commute time for patients.

Jennifer Tinkler, FNP

att 5
SB 2052
3-7-17

AARP Real Possibilities in

North Dakota

March 7, 2017

North Dakota House of Representatives Human Services Committee

Testimony in support of SB 2052

Mike Chaussee – AARP North Dakota

mchaussee@aarp.org, (701) 390-0161

Chairman Weisz and members of the House Human Services Committee. My name is Mike Chaussee with AARP North Dakota. We are here to support SB 2052.

AARP founder, Dr. Ethel Percy Andrus understood the need for access to quality and affordable health care for all. Her tireless drive to advocate for older Americans began when she found a former colleague living in a chicken coop, in great part due to health care costs and the lack of insurance. This is a bill Dr. Andrus would appreciate.

AARP is engaging across the country on the issue of telehealth. We know health care providers, payers and even technology developers are supporting the use of telemedicine in North Dakota and across the country. We are here to speak on behalf of consumers.

Utilization of telehealth services has been found to increase access to care for patients and caregivers, especially those in rural areas. It helps specifically with transportation barriers that can often drain energy and money from both patients and the people who take care of them at home. It also puts additional focus on home and community based services (HCBS) that help North Dakotans remain in their homes and communities for as long as possible.

/

AARP has been diligent in its support of family caregivers. We'll keep up our fight for them because we believe they are the lifeline for older North Dakotans who desperately want to remain at home. Telehealth has proven to help family caregivers do a better job by closing the information gap between them and providers. A report in the Journal of International Nursing backs this up. It says telehealth helps create a partnership between the caregiver at home and the doctors and nurses at the health care facility.[1]

Additionally, it is a money saver across the board for providers, patients and insurers. A recent brief released by the American Hospital Association cites the Veteran Health Administration's success with telehealth. It states an average annual savings of $6,500 per patient who uses telehealth. Additionally, it shows a 25 percent reduction in bed days and a 19 percent reduction in hospital admissions from patients utilizing telehealth.[2]

It's for these reasons that we support Senate Bill 2052. Opening more doors for the advancement of telehealth in North Dakota is good for patients and family caregivers. We urge you to vote 'do pass' on Senate Bill 2052.

Thank you

[1] Chiang, Li-Chi, et al. The effectiveness of telehealth care on caregiver burden, mastery of stress, and family function among family caregivers of heart failure patients: A quasi-experimental study. International Journal of Nursing. April, 2012.

[2] Issue Brief (2016), Telehealth: Helping Hospitals Deliver Cost-Effective Care. American Hospital Association.

SANFORD HEALTH

Att. 6
SB 2052
3-7-17

House Human Services Committee
Rep. Robin Weisz, Chair
March 7, 2017

Chairman Weisz and members of the Committee: My name is Marnie Walth and I represent Sanford Health. Thank you for the opportunity to share thoughts on SB2052.

For rural states like North Dakota where workforce is stretched thin and demand outpaces supply, telemedicine is emerging as a convenient, cost-effective alternative to traditional face-to-face consultations and examinations. Sanford Health increasingly employs telemedicine to improve access to services and reduce patients' costs associated with long-distance travel.

That said, Sanford Health is neutral on SB2052 in that we believe the bill's intent to legislate coverage requirements and use of the technology is not necessary. The health insurance market already recognizes and supports an increasingly robust demand for telemedicine technology (all major health plans in North Dakota already pay for telemedicine services); and the N.D. Board of Medicine is working to put in place rules delineating how and when medical providers may employ telemedicine and for which services.

If the bill moves forward, Sanford Health strongly encourages keeping in place the language that prohibits interfering with insurer-provider negotiations. Telemedicine technology is advancing quickly and so avoiding barriers that may constrain innovation or drive up costs by dictating provider reimbursement rates is critical. As an example, requiring parity payment for a pinkeye diagnoses when a telehealth visit may cost $50, a clinic visit $200 and a trip to the emergency room $600, would drive costs up rather than down.

Thank you for your time. I would be happy to answer any questions you might have.

Marnie Walth
marnie.walth@sanfordhealth.org
701-323-8745

PREPARED FOR HOUSE HUMAN SERVICES COMMITTEE

Att. 1 SB 2052
3-8-17

DRAFT AMENDMENTS TO SENATE BILL NO. 2052

Page 2, line 19, remove "which is the same as the coverage for health services"

Page 2, remove line 20