MEDICAID REDESIGN TELEHEALTH STAKEHOLDER WORKGROUP

FINAL REPORT

Submitted August 2017
to the Alaska Department of Health and Social Services

Prepared by
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GOALS FOR MEDICAID REDESIGN + EXPANSION

IMPROVE HEALTH

OPTIMIZE ACCESS

INCREASE VALUE

CONTAIN COSTS

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Foreword

This report is submitted to Valerie Davidson, Commissioner, Alaska Department of Health and Social Services, from the Alaska Medicaid Redesign Telehealth Stakeholder Workgroup.

1. Introduction

Medicaid Redesign Telehealth Workgroup

Senate Bill (SB) 74, passed by the Alaska Legislature in 2016, enacts comprehensive reform of Alaska's Medicaid program. The Department of Health & Social Services is implementing SB 74 through a series of 16 different initiatives. The Telehealth initiative includes the Telehealth Workgroup, convened to provide advice to the department on improving access to health care through the expanded use of telehealth in Alaska. SB 74 directs the department to identify ways to expand the use of telehealth to improve access to primary care, behavioral health and urgent care services. The legislation further directs the department to consider areas of the state where improvements in telehealth capabilities would be most effective in reducing Medicaid costs and improving access to health care services. In recognition of the challenges the department may face in moving forward with this directive, the bill also requires the department to identify legal and technological barriers to the expanded use of telehealth and recommendations for changes or investments that would allow cost-effective expansion of telehealth services.[1] SB 74 funded the department to convene the workgroup for one year, fiscal year 2017. This report provides an overview of the issues discussed and associated recommendations identified by the Telehealth Workgroup.

Membership

The Medicaid Redesign Telehealth Workgroup is an active group of 15 members representing health care providers, tribal health organizations and Medicaid recipients.

Please see membership list in Appendix A for further information on members.

Method

The workgroup met officially four times and held one ad hoc meeting during fiscal year 2017. Discussions focused on identifying barriers to expanding the use of telehealth options, and developing recommendations to address those issues. DHSS staff members Christiann Stapf and Donna Steward provided leadership for the workgroup and conducted research on Medicaid regulations, data, and other items. Contractor Agnew::Beck provided facilitation and meeting support, and drafted and finalized this report. Below is the project timeline:

- September and October 2016: DHSS invites workgroup participants to apply and selects members.
- November 2016: first workgroup meeting to review SB 74, agree to the charge of workgroup, review and revise workplan.
- February 2017: second workgroup meeting to identify and categorize issues and barriers related to expanding telehealth.
- March 2017: third workgroup meeting to refine list of issues and barriers to focus on those related specifically to telehealth, and to identify possible solutions.
- May 2017: workgroup held an ad hoc meeting to identify possible cost reductions from use of telehealth.
- June 2017:
    - Fourth workgroup meeting to review draft report and finalize recommendations.

[1] SB 74, Section 43

- Revise report and submit draft to DHSS for review.
- Finalize draft and submit to DHSS.

Definition and Usage of Terms: Telehealth and Telemedicine

The definitions of 'telehealth' and 'telemedicine' continue to evolve. The American Medical Association reports that "there is no consensus on the definition of either of the two terms".[2] The American Telemedicine Association reports that model legislation developed by the National Association of Insurance Commissioners[3] adopts a definition that is "concise and modality-neutral: "Telemedicine" or "Telehealth" means health care services provided through telecommunications technology by a health care professional who is at a location other than where the covered person is located."[4]

Alaska Senate Bill 74 passed in 2016, used the term 'telehealth' in its final version, rather than 'telemedicine' and defines the term broadly as "the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other."[5] This definition is essentially similar to the definition used by the National Association of Insurance Commissioners described above, but includes more specificity for the terms 'health care services', 'telecommunications technology' and the relationship between the health care professional and the person receiving care. The definition used in SB 74 also specifically identifies telehealth services as those that occur between providers who are physically separated from each other.

Alaska Medicaid uses the term 'telemedicine' rather than 'telehealth'. The program "will pay for medical services furnished through telemedicine applications as an alternative to traditional methods of delivering services to Medicaid recipients." [6]

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[2] https://www.ama-assn.org/delivering-care/telemedicine-mobile-apps#Telemedicine accessed June 22, 2017.

[3] http://www.naic.org/store/free/MDL-74.pdf accessed June 22, 2017.

[4] https://thesource.americantelemed.org/blogs/jessica-washington/2017/04/20/hhs-market-stabilization-rule-defers-network-adequacy-assessment-to-states accessed June 22, 2017.

[5] http://www.legis.state.ak.us/PDF/29/Bills/SB0074Z.PDF accessed May 5, 2017.

[6] 7 AAC 145.270. Telemedicine payment rates: (a) The department will pay for a service rendered by a consulting or referring provider by a telemedicine application in accordance with 7 AAC 145.020. (b) Payment to the presenting provider is limited to the rate established for brief evaluation and management of an established patient. (c) The department will pay the receiving provider in the same manner as payment is made for the same service provided through traditional mode of delivery, not to exceed 100 percent of the rate established under 7 AAC 145.050. (d) In this section, "consulting provider," "presenting provider," "referring provider," and "telemedicine" have the meanings given in 7 AAC 110.639.

2. Workgroup Recommendations

Legal + Policy

Issue 1: Reimbursement for care management and use of remote monitoring strategies in home settings

Medicaid does not allow reimbursement for care management outside of a Targeted Case Management program. Care management activities that reimburse a provider for coordinating patient care among providers, monitoring adherence to medication schedules and contacting at-risk patients to check status are typical services found in managed care programs, innovative provider payment models and primary care medical home models, none of which are yet implemented in Alaska.

Also absent is the broad ability to use remote-monitoring strategies in the home setting, such as those authorized by a 1915(c) home and community-based services waiver. Remote patient monitoring, including blood pressure, glucose levels, and weight, allows providers to monitor changes and work with patients to improve health outcomes. This allows the provider to regularly review data and check in with the patient frequently using evidence based models and technologies.

Alaska's Senior and Disabilities Services (SDS) has convened a technology committee to identify ways to reimburse for in-home remote monitoring and assistive technology as part of Alaska Medicaid's 1915(c) waiver programs. Possible telehealth programs could target high cost enrollees engaging them with remote health monitoring strategies to improve chronic disease management and reduce related health care costs. These strategies could include video monitoring in the home, supervision and cueing to reduce in-person personal care hours for prompting and medication management. Rendering case management, medication management and other services through telehealth in the patient's home may help identify and address chronic conditions by, for example, a nurse case manager interacting with a patient using their iPad to ask how their medications are working; all of this can help reduce the potential for emergencies, which may reduce costs.

For in-home remote monitoring applications to be successful, patients and their families must be trained to use the technology. Patients may refuse to use the technology, especially if they are not comfortable with the application.

Similarly, Mobile Health services are also not reimbursed by Alaska's Medicaid program but may improve health outcomes by sending appointment or medication reminders, distributing education materials on chronic or other illnesses, and tracking patient activities.

Recommendation 1:

a. Monitor the implementation of the Alaska Coordinated Care Demonstration Projects that will implement care management for specific Medicaid populations and the use of innovative payment models to reward value and improved patient outcomes. Specifically evaluate the return on investment for telehealth strategies within these pilot projects, which will test innovative payment models.
b. Monitor the results of the SDS technology committee and any pilot projects that result for participants in the 1915(c) waivers. Evaluate if these strategies could be employed for other Medicaid-eligible groups.

c. Monitor the implementation of the proposed 1115 behavioral health waiver that will potentially offer home-based services to other high-cost Medicaid populations to evaluate if increased care management and in-home services, provided via telehealth, would improve outcomes.
d. Evaluate the cost-benefit for establishing a bundled rate to reimburse providers for time to travel to the home, set up equipment and to instruct the patient and family on how to use equipment for specific populations

Issue 2: Prescriptions for controlled substances

Federal law prohibits the issuance or renewal of a prescription for a controlled substance without a face-to-face examination of a patient, which limits a patient's ability to receive services via telehealth if there is a high likelihood that a prescription for a controlled substance will be necessary to treat the patient's condition. The language adopted in Alaska law incorporates the federal allowance for a physician to write a prescription for a controlled substance based on a telemedicine encounter if a "licensed health care provider" is physically present with the patient to assist with the examination conducted by the provider delivering the telehealth service. Federal law allows the practice of telemedicine "while the patient is being treated by, and in the physical presence of, a practitioner." It defines a 'practitioner' as "a physician, dentist, veterinarian, scientific investigator, pharmacy, hospital, or other person licensed, registered, or otherwise permitted, by the United States or the jurisdiction in which he practices or does research, to distribute, dispense, conduct research with respect to, administer, or use in teaching or chemical analysis, a controlled substance in the course of professional practice or research."[7] The federal definition is broader and provides greater flexibility as to who may be present during a telehealth examination that could lead to prescription of a controlled substance.

If Alaska were to amend state law to adopt the federal definition for 'practitioner', rather than the more narrowly defined "licensed health care provider", it would allow Community Health Aides and Practitioners, who work within the tribal health system under the supervision of a physician and are certified in their positions by the Indian Health Service, to be present with a patient while an exam is conducted by a physician via telehealth. The exam could then result in the prescription of a controlled substance while complying with federal law intended to stop the diversion of controlled substances from appropriate medical uses.

Alaska's SB 74 includes the language below with the intention of allowing prescriptions via telehealth, however, the inclusion of the term "licensed health care provider" does not allow a Community Health Aide or Practitioner to meet the requirement of being present with the patient during the exam.

> The board may not impose disciplinary sanctions on a physician for prescribing, dispensing, or administering a prescription drug that is a controlled substance or botulinum toxin if the requirements under (a) of this section are met and the physician prescribes, dispenses, or administers the controlled substance or botulinum toxin when an appropriate licensed health care provider is present with the patient to assist the physician with examination, diagnosis, and treatment.[8]

Recommendation 2:

Amend Alaska State law to change AS 08.64.364(c) reference from "appropriate licensed health provider" to "practitioner" as defined by federal law cited above.

[7] https://www.deadiversion.usdoj.gov/21cfr/21usc/802.htm accessed June 22, 2017.

[8] http://www.legis.state.ak.us/PDF/29/Bills/SB0074Z.PDF and AS 08.64.364(c) accessed June 22, 2017.

Issue 3: Board regulation

Although telehealth strategies have been used throughout the state for some time, to eliminate any potential concerns about professional board sanctions for delivering services using a telehealth strategy, SB 74 expressly prohibits professional boards from sanctioning providers for delivering services via telehealth. The measure also requires the boards to update their policies to clarify a provider's ability to use telehealth as a delivery strategy.

Recommendation 3:

Ensure state medical and licensing boards update their regulations to allow professionals to provide telehealth services consistent with SB 74 and with the definition of telehealth included in SB74.

Issue 4: Require all payers to reimburse for telehealth at parity

As with many proposed reforms, for providers to make investments in practice improvements there must be a reasonable assurance of sufficient billable revenue to offset those investments. Perhaps because of conflicting information regarding the efficacy of telehealth services versus in-person visits, or for other reasons, some private payers currently do not reimburse for telehealth services. It may be that with correct coding, these services would be reimbursed.

In 2008, the Mental Health Parity and Addiction Equity Act passed at the federal level, which prevents group health plans and health insurance issuers that provide mental health or substance use disorder benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits. This law was strengthened by the passage of the Affordable Care Act in 2010 to also apply to individual health coverage.[9] No similar federal law exists for coverage of telehealth services.

Thirty-two states and the District of Columbia have parity laws that cover private insurers and reimbursement for telehealth services. These laws require commercial health insurance companies to cover services provided through telehealth to the same extent as those services are covered in person. Many variations exist in how public programs and private insurers pay for these services and which services they cover. While many states mandate reimbursement, not all require reimbursement to be equivalent to or at the same rate as in-person services. Colorado, Missouri, and Virginia require payment on the same basis as in-person services, which allows them to take into consideration the cost differences of telehealth versus in-person services. Twenty-three states and the District of Columbia have full parity, meaning coverage and reimbursement is comparable from in-person to telehealth services. Arizona is the only state that limits parity to geographic regions and specific services. Michigan, Oregon, and Vermont only authorize reimbursement for telehealth that uses interactive, audio-visual systems, and Arkansas places limits on patient locations and provider types, as well as requiring an in person visit to establish a patient-provider relationship. Nevada is the only state to extend parity to workers' compensation programs.[10]

[9] Center for Consumer Information & Insurance Oversight, CMS, https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html accessed June 23, 2017.

[10] Ibid.

Recommendation 4:

Pass a law in Alaska to require parity among all payers for telehealth services.

Work with the Alaska Division of Insurance to conduct work sessions with health care payers in Alaska to develop acceptable language to include in legislation.

Issue 5: Improve coordination between schools and providers to expand the use of telehealth for assessments and consultations during the Individualized Education Program (IEP) process.[11]

Individualized Education Plans govern special education and other supportive services eligible children receive in schools, some of which are reimbursed by Alaska Medicaid. The assessment and consultations that develop the IEP require coordination between physicians, school staff, and other professionals. Telehealth services can be used to increase access to specialist services especially to rural students who may not otherwise have access to them. Improved coordination between the medical providers and school-based staff is needed to improve the efficiency and effectiveness of these services.

Recommendation 5:

Work with the Alaska Department of Education and Early Development to develop a centralized data repository to track client/patient history and IEPs.

Identify services, such as speech therapy, that could be delivered via telehealth.

Analyze the utilization of school-based services to avoid duplication and ensure coordination between schools and providers.

Technology

Issue 6: Internet access at village clinics is typically sufficient to support video-based telehealth if adequate funding continues to support these high-speed connections.

Rural Alaska greatly benefits from the extensive hub and spoke network of clinics, hospitals, and providers managed by the Alaska Tribal Health System. As described above, this system has been developed over recent decades and provides a robust telehealth network that increases access to care in rural Alaska. Continued funding will be necessary to continue this system and ensure access to health services for all Alaskans.

Recommendation 6:

Alaska currently receives $82m from the USAC Rural Health Care Fund, which accounts for 25% of the nation's funding.[12] Support the collaborative efforts of ASHNHA, GCI Health Care and other partners to advocate federally to increase the cap on these funds to secure $600 million to address

[11] Individualized Education Program, is a written document that's developed for each public school child who is eligible for special education.

[12] Communication from Connie Beemer; additional information provided here http://www.usac.org/rhc/ accessed May 5, 2017

Internet coverage in rural areas.[13] Continue to advocate for support of the telehealth network serving rural Alaska.

Issue 7: Lack of a central telehealth network

Alaska lacks a centralized system to identify providers who provide telehealth services, which services are provided using telehealth, how to access telehealth-enabling technology, and how to schedule with a provider that delivers services using telehealth. While SB 74 provides for a directory of telehealth providers, it lacks important details. Creating a centralized system that assists providers, patients and families with connections to telehealth services will help identify available providers and eliminate barriers to services.

Recommendation 7:

Work with Alaska Health Information Exchange and the Department of Commerce, Community, and Economic Development to identify the most feasible information technology to support a central network for Alaska's telehealth providers.

Issue 8: Help providers invest in equipment and connectivity to support telehealth strategies

It is expensive for providers to access the connectivity and equipment necessary for telehealth. There are subsidized programs but they are complicated and difficult to access. The most sustainable approach to helping providers invest in telehealth equipment and connectivity is to create reimbursement incentives for utilizing telehealth delivery methods.

DHSS is supporting the development and connection to the Health Information Exchange (HIE). This will increase connectivity among providers and allow for the appropriate exchange of health information. The HIE may be a critical piece of infrastructure to increase provider use of telehealth and to facilitate access to telehealth services, as well as allowing providers to view and submit information to a patients' electronic health record.

Recommendation 8:

As indicated above, passing a parity law in Alaska to ensure all payers reimburse for telehealth services, will also increase the incentive for providers to invest in the necessary equipment and connectivity.

Continue to support the development of Alaska's HIE and to increase connections to it among Alaska providers.

Data

Issue 9: Lack of Data to Identify High Need and/or Shortage Areas

A complete review of current Alaska Medicaid program expenditures on telehealth services, including services delivered, diagnosis codes supported through telehealth, location of recipients, and provider types, will be necessary for the program to identify high need and provider shortage areas that may be served through expansion of telehealth capabilities.

[13] See House Joint Resolution 14 (add a link to this here)

Recommendation 9:

Identify baseline data for cost and utilization of telemedicine services for Alaska Medicaid.

Develop and routinely prepare data reports on telehealth utilization among Alaska Medicaid enrollees to analyze telehealth utilization by location, provider type, diagnosis code, and service category. Use reports to determine priorities for targeted telehealth expansion.

Stakeholder Engagement

Issue 10: Lack of venue to convene stakeholders across the health system for ongoing analysis of telehealth utilization and potential cost savings.

The workgroup would like to continue to meet on a regular basis for one-hour webinars on topics related to telehealth expansion in Alaska. Ideally, the workgroup would meet in person on a quarterly basis to review data analyses, pursue strategies related to telehealth expansion, and to provide educational opportunities related to telehealth policy. The workgroup identified the following potential topics: Drug Enforcement Administration representatives to discuss policies related to prescribing controlled substances and telehealth; representatives from Department of Commerce, Community and Economic Development related to the telehealth business registry and the development of a provider network; and, representatives from the Department of Education and Early Development and the Governor's Council for Disabilities and Special Education related to the coordination of school and medical professionals for Medicaid services delivered in school settings.

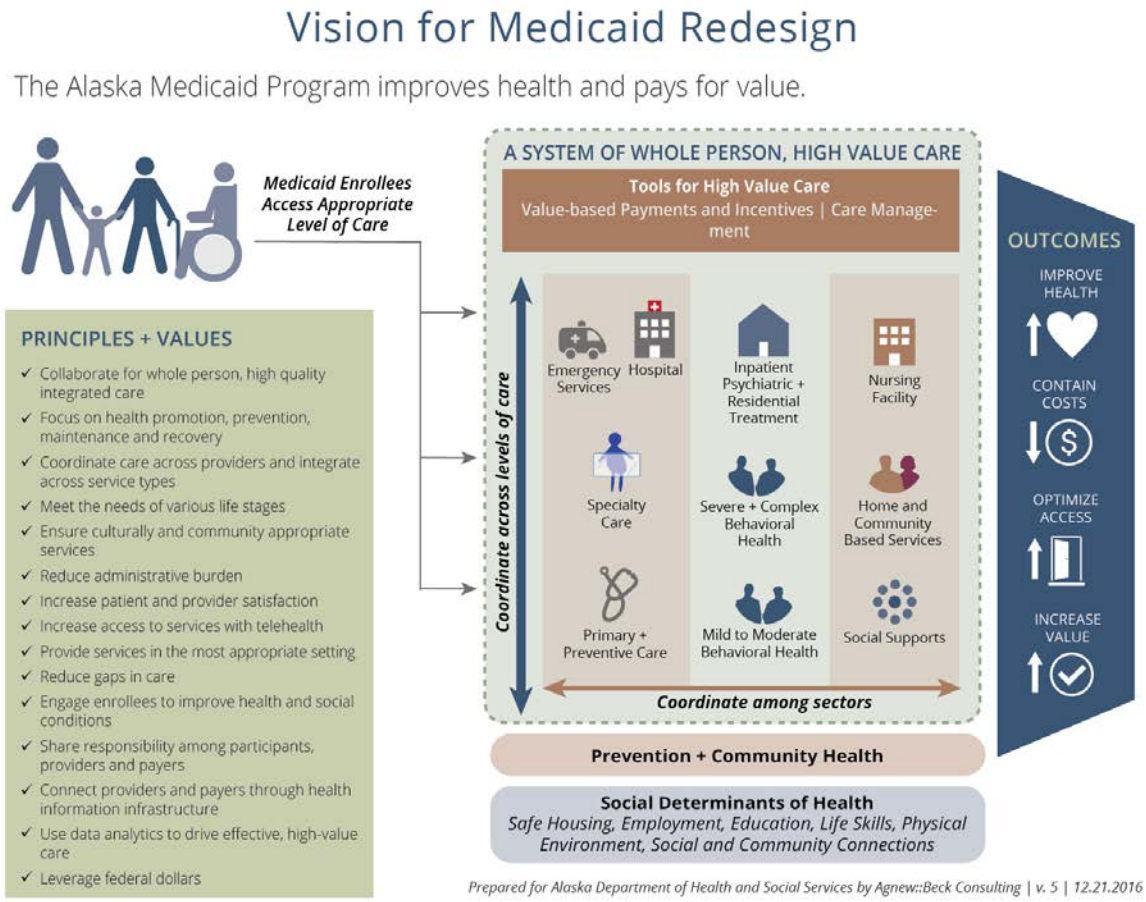
Recommendation 10:

Provide DHSS staff support to offer ongoing coordination of the telehealth workgroup for regular webinars and half-day quarterly in-person meetings.

3. Background

Alaska Medicaid Redesign Process

During fiscal years 2016 and 2017, a range of stakeholders worked with the Department of Health and Social Services to provide input to the Alaska Medicaid Redesign process. As part of this process, stakeholders provided input to design, refine, and prioritize the vision and goals for the redesign of Alaska's Medicaid program, which is depicted in the diagram below. The Telehealth Workgroup referred to this vision diagram during their discussions.



Redesign efforts are essential to improving health outcomes for Alaska Medicaid recipients while ensuring the financial stability of the program. Vulnerable Alaskans often access care at a higher than necessary level of service intensity and at increased expense to the program, because lower-level services that could address the underlying health issues are not accessible. Addressing the social determinants of health is necessary to improve population health, and while many of the programs and divisions within the Department of Health and Social Services address these, this is largely beyond the scope of the Alaska Medicaid program. Alaska Medicaid can and is working to change utilization patterns by improving enrollee access to primary and preventive care to reduce costs for Medicaid while also improving care and enrollee health. Addressing provider shortages is also essential to reform efforts. In many areas, some services, such as psychiatry, are not

accessible or available to those who need them. To address this issue, it will be essential for Alaska Medicaid to develop strategies that build provider capacity in non-traditional ways, such as expanding the use of telehealth services.

Coordinating and managing care to improve the ability of Medicaid recipients to receive the right care at the right time will also help support improved health outcomes, and is an important component of redesign efforts; however, incorporating care coordination and management into Alaska's existing fee-for-service model is a challenge. Currently, Alaska is one of only two states whose Medicaid program relies exclusively on a fee-for-service (FFS) provider payment model. During the development of recommendations to redesign Alaska's Medicaid program in late 2015, stakeholders concluded that the current payment model does not encourage providers to coordinate and manage care or reward providers for providing care earlier and in lower care settings. In response, several Medicaid Redesign projects are tasked with focusing specifically on development of care coordination and management, accompanied by innovative provider payment models, to encourage expansion of care coordination and management activities. The Medicaid Redesign Coordinated Care Demonstration Project (CCDP) is one example, and SB 74 specifically requires CCDP projects to include a telehealth component.

Role of Telehealth in Achieving Goals of Redesign

One of the most promising aspects of telehealth is the ability to increase provider and enrollee access to primary and specialty care services. The ability for a patient to receive consultation services from a specialist without leaving his or her home community can reduce the time necessary for the patient to begin the best course of treatment and reduce utilization of services that will not improve the patient's health. Telehealth has been especially successful at increasing access to behavioral health services in a confidential and stigma-free setting.

Other states have also found that the use of telehealth strategies that do not involve direct patient care have been helpful. Such strategies include options for providers to consult with specialists on difficult cases, receive expert clinical support when the provider is isolated and would otherwise need to send their patients out of the community for services, and participate in general clinical education opportunities. In addition to improving access for Medicaid recipients, increasing the use of telehealth for primary care, behavioral health, and specialty services may also reduce the need for non-emergency travel and reduce emergency travel necessitated by the escalation of conditions left untreated. Actuarial analysis completed by Milliman, Inc. for DHSS in 2015 estimated a potential savings to the Medicaid program of $2.6 million in the first year, increasing to $13 million in year four, in response to expanded use of telemedicine capabilities.[14] These projections were based in part on assumptions that increased use of telemedicine would result in decreased utilization of emergency department and other medical services.

Through discussions of the Telehealth Workgroup, cursory analysis of recent data from Alaska Medicaid, and a review of other states' use of telehealth, the group has concluded that these options are usually built into provider payment structures that support managed care such as primary care medical homes, accountable care organizations, and other non-FFS payment models. These options could not be adapted into Alaska's current fee-for-service model, because federal Medicaid regulations prohibit FFS reimbursement for consultation between providers. In fact, because Alaska Medicaid currently pays the same rate for a telemedicine service as it does for an in-person service without control measures in place related to the health outcome from the

[14] cite A::B Medicaid Redesign Report

service, there is some financial incentive to increase the use of telemedicine services without a reduction in in-person services, which may increase costs for Alaska Medicaid while not resulting in an improvement in enrollee health outcomes.

The Telehealth Workgroup has voiced strong support for expanding access to telehealth services, but also caution to ensure that each provider delivering telehealth services is enrolled as a Medicaid provider in the state of Alaska. Anecdotally, providers report using Mobile Health (eHealth) services to provide patient support through mobile communication such as texting and phone calls. Providers report that many patients prefer these methods of consulting physicians rather than coming in for an office visit and can be more efficient and cost-effective for the provider and payer. These services are not currently reimbursed by Alaska Medicaid, in part because these and other forms of routine care management are not reimbursable services outside of a Targeted Case Management program. These approaches are also not covered by other payers in the state of Alaska but as the department implements care management approaches, as part of ongoing Medicaid Redesign efforts, these approaches will be further explored.

Brief History of Telehealth in Alaska

Alaska has a strong history with telehealth, particularly in the tribal health system, where it is routinely used to evaluate conditions and provide behavioral health treatment services. The expansion of telehealth services was greatly aided by the development of the Alaska Federal Health Care Access Network; 99 percent of telehealth events on this system originated within the Indian Health Service-funded healthcare delivery system.[15]

The non-tribal health system in Alaska has also collaborated to increase adoption of telehealth in Alaska, including efforts by individual providers and support from the Alaska State Hospital and Nursing Home Association (ASHNHA). For example, in 2009, Providence became Alaska's base hospital offering telehealth-based stroke care assessments statewide. Providence's Telestroke program allows neurologists to remotely diagnose and recommend treatment for stroke patients in rural, local, and remote areas using Providence's secure Telehealth infrastructure. This web-based telehealth system, called Remote Evaluation of Acute isCHemic stroke (REACH), allows the consulting neurologist to evaluate stroke patients in multiple locations around Alaska within ten minutes.[16]

Providers are increasing their use of telehealth strategies but efforts are often limited to a specific health system. Barriers to increased use of telemedicine options in the non-tribal health system include issues related to technology and coordination, reimbursement from varied payer sources, regulatory issues, and the lack of a single organization with a focus on statewide telehealth development.[17] Some providers are reluctant to invest in the technology necessary to engage in telemedicine because not all payers provide reimbursement for telehealth services. While Alaska's Medicaid program is one of forty-six state programs that reimburses for telemedicine services, other payers such as some private insurers, are reluctant to pay for services delivered through telehealth. Providers serving more private pay patients are thus reluctant to invest in technologies that may only be used with a subset of patients.

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[15] Evolution & Summative Evaluation of the Alaska Federal Health Care Access Network Telemedicine Project, University of Alaska Statewide Health Programs, November 2004.

[16] http://alaska.providence.org/locations/pamc/services/stroke/Pages/emergencystroke.aspx, accessed May 5, 2017

[17] Telehealth in Alaska's Hospitals- Identified Issues, Needs and Opportunities, October 2014. A collaborative effort between the Alaska State Hospital and Nursing Home Association, DHSS and the Denali Commission.

Currently, the Alaska Medicaid program supports telemedicine as a method to deliver a specific health care service. Telemedicine itself is not a distinct and separately billable service. Providers engaging in telemedicine receive the same payment for the service delivered as if the patient met with the provider in the provider's office. Alaska Medicaid only covers telemedicine services provided through one of these three methods:

- *Interactive method:* Provider and patient interact in "real time" using video/camera and/or dedicated audio conference equipment.
- *Store-and-forward method:* The provider sends digital images, sounds, or previously recorded video to a consulting provider at a different location. The consulting provider reviews the information and reports back his or her analysis.
- *Self-monitoring method:* The patient is monitored in his or her home via a telemedicine application, with the provider indirectly involved from another location.[18]

Alaska is one of only three states that cover all three of these methods.[19] A provider may fulfill one of the following three roles in the telemedicine process to be eligible for reimbursement by Alaska Medicaid:

- *Referring provider* is a provider who evaluates a member, determines the need for a telemedicine consultation, and arranges the services of a telemedicine consulting provider for diagnosis or treatment.
- *Presenting provider* is a provider who introduces a member to a telemedicine consulting provider for examination, observation, or consideration of medical information; they may also assist in the telemedicine consultation.
- *Consulting provider* is a provider who evaluates the member and appropriate medical data or images through an approved telemedicine delivery method upon recommendation of the referring provider. The consulting provider may or may not be providing "consultation" services.[20]

Table 1 outlines telemedicine allowances under Alaska's current Medicaid program.

Table 1. Status of Telemedicine in Alaska's Medicaid Program[21]

CRITERIA FOR COVERAGE	TELEMEDICINE SERVICES COVERED BY ALASKA MEDICAID
• Covered by Alaska Medicaid • Provided by an Alaska Medicaid enrolled provider within the scope of their license or certification • Rendered to a member eligible to receive those services • Appropriate for telemedicine delivery	• An initial visit • A follow-up visit • A consultation made to confirm a diagnosis • A diagnostic, therapeutic, or interpretive service • A psychiatric or substance abuse assessment • Psychotherapy • Pharmacological management services on an individual member basis

[18] http://manuals.medicaidalaska.com/physician/physician.htm#prof_ii/Section_ii_professional_claims_management.htm

[19] State Telehealth Policies and Reimbursement Schedules: A Comprehensive Plan of the 50 States and District of Columbia. Center for Connected Health Policy. September 2014.

[20] Ibid.

[21] Ibid.

• Performed using a specified delivery method	Consistent with provider recordkeeping requirements, a member's record must include the medical need for the telemedicine service.

COSTS + SERVICES NOT COVERED

- Use of telemedicine equipment and systems
- Services delivered by telephone when not part of a dedicated audio conference system
- Services delivered by facsimile
- The following services provided by telemedicine application:
    - Direct entry midwife
    - Durable medical equipment (DME)
    - End-stage renal disease
    - Home and community-based waiver
    - Personal care assistant
    - Pharmacy
    - Private duty nursing
    - Transportation and accommodation
    - Vision (includes visual care, dispensing, or optician services)

Telehealth in SB74

SB 74 includes telehealth as an important strategy for redesign of the Alaska Medicaid program and anticipates the opportunities for expansion of telehealth to be complementary to redesign efforts. The following provisions in the legislation refer to telehealth:

- Prohibits professional clinician licensure boards from imposing disciplinary sanctions on licensees for practice via audio, video, or data communications when physically separated from the patient within certain criteria. The boards for the following practitioners are addressed in the Act:
    - Audiologists (Section 1)
    - Speech-language pathologist assistants (Section 2)
    - Speech-language pathologists (Section 3)
    - Professional Counselors (Section 4)
    - Marital and Family Therapists (Section 6)
    - Physicians (Sections 7, 8, and 9)
    - Physical and Occupational Therapists (Section 13)
    - Psychologists and Psychological Associates (Section 14)
    - Social Workers (Section 15)
- Requires the Department of Commerce, Community & Economic Development to establish and maintain a Telemedicine Business Registry of businesses performing telemedicine services in the state. (Section 38)
- Requires the Medicaid program to expand the use of telehealth for primary care, behavioral health, and urgent care. (Section 43)
- Requires the Department of Health & Social Services (DHSS) to:

    - identify areas of the state where improvements in access to telehealth would be most effective in reducing Medicaid costs and improving access to care for Medicaid recipients;
    - improve access to telehealth for recipients in those locations; and,
    - enter into agreements with Indian Health Service providers, if necessary, to improve access by medical assistance recipients to telehealth facilities and equipment. (Sec. 43)

- Requires DHSS to include in an annual report on Medicaid reform to the legislature information on the legal and technological barriers to expanded use of telehealth, improvements in the use of telehealth in the state, and recommendations for changes or investments that would allow cost-effective expansion of telehealth. (Section 43)
- Allows DHSS to increase the capability for and reimbursement of telehealth for Medicaid recipients. (Section 45)
- Requires that proposals for Coordinated Care Demonstration Projects include information demonstrating how the project will implement cost-saving measures, including innovations to reduce the cost of care for Medicaid recipients through the expanded use of telehealth for primary care, urgent care, and behavioral health services. (Section 46)
- Requires the Department of Health & Social Services to identify legal or cost barriers preventing the expanded use of telehealth and recommend remedies for identified barriers. (Section 46) [22]

Within the existing Medicaid program, the workgroup focused its efforts on the barriers to expanding the use of telehealth and potential solutions to eliminating these barriers. The workgroup had two robust discussions regarding barriers and from these discussions, developed the recommendations included in Section 2.

One element that inhibited the workgroup's ability to evaluate areas in the state where telehealth may be of most benefit was the lack of Alaska Medicaid data identifying the services currently billed as telehealth, the scope of providers using telehealth, and the location of recipients receiving services through telehealth. Without a clear understanding of current utilization of telehealth services paid for by Alaska Medicaid, the workgroup was unable to develop informed strategies to expand telehealth in provider shortage areas, and to contain costs for Alaska Medicaid.

One of the primary issues discussed by the workgroup was the use of new technologies to monitor patient health and manage care needs. The workgroup discussed strategies for providers to enhance care management through routine phone calls to patients to check status, use of texting and cell phone alerts to send reminders, and to provide education on chronic and other illnesses. There was agreement among workgroup members that additional reimbursement from the Medicaid program would be necessary for providers to exercise these options to serve Medicaid populations. While such care management activities are not currently supported by the Alaska Medicaid program as either a general reimbursable service or a telehealth strategy, other SB 74 redesign efforts focusing on care coordination, innovative provider payments, and primary care medical homes could incorporate one or more of these strategies as they move forward.

Outcomes from Telehealth

Most state Medicaid programs allow the use of some form of telehealth option to deliver care to beneficiaries. As discussed above, Alaska is one of only two states that operates its Medicaid program solely with a fee-for-service payment model. Because of this, other states' experiences are not necessarily analogous to Alaska. In

[22] http://www.legis.state.ak.us/PDF/29/Bills/SB0074Z.PDF Accessed May 5, 2017

other states, cost savings created by telehealth are part of broader managed care efforts that utilize care management strategies, rather than a fee-for-service program structure.

For example, a recent study evaluated the impacts of a telemonitoring program that specifically targets Medicare managed care members enrolled in the Geisinger Health Plan (GHP) who lived in rural Central Pennsylvania and had experienced heart failure. The program provided participants with in-home technology specifically designed to detect changes in physical condition indicating exacerbation, such as shortness of breath, swelling, appetite, and prescription management. The study found that the telemonitoring program was associated with significant reductions in hospital admission and readmission rates, which translated into approximately 11% cost savings and a return on investment of approximately 3.3.[23] However, the study specifically notes that "GHP's telemonitoring program was implemented as an additional tool and resource to augment the existing case management infrastructure and not as an independent, stand-alone program carved out specifically for members with heart failure. Embedding this tool within the daily workflow of case managers has allowed them to track each member's clinical progress in near real time, increasing the opportunities for proactive intervention based on biometric and symptom information."[24] Because the use of the in-home technology was embedded into the managed care rate paid to the participating providers, no additional reimbursement was provided for use of the technology.

A similar approach was piloted in Mississippi to provide remote monitoring for patients with diabetes. The Center for Telehealth, created in 2003, developed the Diabetes Telehealth Network in early 2014. The program allowed health practitioners to treat patients remotely, in real time and at home, using online streaming video technology and other tools for two-way live communication. Participants were trained on tablet computers loaned at no cost and requiring a cellular broadband connection. Preliminary data from the diabetes patients showed 96 percent took their medications as directed and 83 percent kept their scheduled telehealth appointments. The data also showed that the patients' average hemoglobin A1c level dropped, bringing them closer to the normal range for those without diabetes. No patients in the study were hospitalized or visited an emergency room because of complications from diabetes. In addition, providers identified nine cases of diabetic retinopathy that might otherwise have gone undiagnosed. The same model is now being deployed for patients coping with chronic obstructive pulmonary disease, hypertension, kidney disease and several other conditions that require chronic disease management. This project was partly enabled by the passage of a law by the 2014 Mississippi Legislature that requires insurance companies and Medicaid to reimburse for both remote patient monitoring and store-and-forward telemedicine.[25]

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[23] The estimated return on investment associated with the telemonitoring program was approximately 3.3. That is, for every $1 spent to implement the program, there was approximately $3.30 return on this investment in terms of the cost savings accrued to the Geisinger Health Plan (GHP). The investment cost was calculated as the sum of the cost of purchasing the Bluetooth scale as well as the cost of the automated calls to the members. The cost was determined on a per member per month (PMPM) basis for each member for the number of the months during which the member was enrolled in the program. The cost associated with case management activities for the members participating in this program was not separately identified and included in this calculation because any case management activity related to the telemonitoring program was considered to be a part of the routine case management efforts performed by the case managers. (Source: same as footnote 17)

[24] Daniel D. Maeng, PhD, Alison E. Starr, DBA, Janet F. Tomcavage, RN, MSN, Joann Sciandra, RN, BSN, CCM, Doreen Salek, BS RN, and David Griffith, BS. Can Telemonitoring Reduce Hospitalization and Cost of Care? A Health Plan's Experience in Managing Patients with Heart Failure. Population Health Management Volume 0, Number 0, 2014. http://www.amchealth.com/_files/published-outcomes/PopulationHealthManagement-GeisingerHFStudy-May2014.pdf accessed June 22, 2017.

[25] https://www.umc.edu/News_and_Publications/Press_Release/2016-10-03-00_UMMC_telehealth_enters_next_chapter_of_remote_patient_monitoring(1).aspx accessed June 22, 2017.

A recent technical brief from the Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, shares the results from an extensive literature review of the evidence for patient outcomes resulting from telehealth. The main conclusions of this brief include:

- The research literature on telehealth is vast and varied, consisting of hundreds of systematic reviews and thousands of studies of use across various clinical conditions and health care functions.
- There is sufficient evidence to support the effectiveness of telehealth for specific uses with some types of patients, including:
    - Remote patient monitoring for patients with chronic conditions;
    - Communication and counseling for patients with chronic conditions;
    - Psychotherapy as part of behavioral health.

  For these telehealth applications, the research focus should shift to how to promote broader implementation and address barriers.
- Additional systematic reviews may be helpful for some topics, such as consultation and maternal and child health, where primary studies are available but these have not been synthesized.
- For other uses, such as triage for urgent care, telehealth is cited as offering value but limited primary evidence was identified, suggesting more studies are needed.
- Future research also should assess the use and impact of telehealth in new health care organizational and payment models[26]

A promising model developed by the University of New Mexico is currently being piloted in Alaska. Project ECHO (Extension for Community Health Outcomes) uses phone and video to connect primary care providers in rural and underserved communities with specialists to co-manage patients with common chronic conditions such as diabetes, hepatitis C and lupus. Evaluations on Project ECHO's use in Colorado found health outcomes in community locations were equal to those of patients at the University hospital campus.[27] This model breaks down the walls between specialty and primary care by linking expert specialist teams at an academic 'hub' with primary care clinicians in local communities. These teams participate in weekly teleECHO™ clinics, like virtual grand rounds, combined with mentoring and patient case presentations. The clinics are supported by basic, widely available teleconferencing technology. During teleECHO clinics, primary care clinicians from multiple sites present patient cases to the specialist teams and to each other, discuss new developments relating to their patients, and determine treatment. Specialists serve as mentors and colleagues, sharing their medical knowledge and expertise with primary care clinicians.[28]

[26] Totten AM, Womack DM, Eden KB, McDonagh MS, Griffin JC, Grusing S, Hersh WR. Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews. Technical Brief No. 26. (Prepared by the Pacific Northwest Evidence-based Practice Center under Contract No. 290-2015-00009-I.) AHRQ Publication No.16-EHC034-EF. Rockville, MD: Agency for Healthcare Research and Quality; June 2016. www.effectivehealthcare.ahrq.gov/reports/final.cfm. accessed June22, 2017.

[27] Health Care for a High-Tech World: The Potential for Telehealth in Colorado, Colorado Health Institute, October 2014. http://www.coloradohealthinstitute.org/sites/default/files/migrated/postfiles/Telehealth_Report_10_15_2014.pdf

[28] http://echo.unm.edu/about-echo/model/ accessed June 22, 2017.

4. Evaluation + Monitoring

The program will need to monitor utilization of telehealth services to ensure the increased use of telehealth improves outcomes for enrollees and contains costs for the Medicaid program. An example of one such expectation is that as telehealth expands, non-emergency and emergency transportation services attributed to lack of routine care and/or monitoring of chronic conditions will go down. Also of interest to the program will be the extent to which expansion of telehealth improves enrollees' access to primary care, behavioral health care, or minor acute care services that would otherwise not be available.

Possible Measures

SB 74 SECTION	EVALUATION MEASURES

Sections 1-4, 6-9, 13-15, 38, 43
 	
Telehealth + Telemedicine
	• Total number of (and change in) telehealth providers (pre/post, over time)
	  o Rate of telehealth by region, service type
	  o In areas where telehealth visits have increased, change in other utilization, total costs
	• Total number of (and change in) telehealth visits
	  o Overall
	  o For specific uses (primary care, urgent care, behavioral health)
	• Percentage of telehealth vs in person visits for same type of condition/issue (total and change over time)
	• Total use of and change in non-emergency medical transportation (NEMT) – number of trips
	• Change in spending on NEMT
	• General access to care measure

Appendix A

Workgroup Members

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Brent	Fisher	Alaska Sleep Clinic
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Laura	Johnston	Southcentral Foundation
Richard	Kiefer-O'Donnell	University of Alaska, Anchorage
Ken	McCarty	Discovery Cove Recovery Center
Trina	McCandless	Haines Borough Fire Department EMS
Robert	Onders, MD	Alaska Native Tribal Health Consortium
Georgiana	Page	Alaska eHealth Network
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Mark	Williams	Providence Health + Services
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