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Introduction

Telehealth: What Is It?

There is an evolving definition of telehealth, but it generally refers to the delivery of health-related services and information via telecommunications technologies. The California Business and Professions Code Section 2290.5 defines telemedicine as “… the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.”

There are many applications for telehealth including medical care for home-bound patients, providing care in geographically remote locations, monitoring for chronic disease/condition management, remote monitoring of at-risk populations, mental telehealth for incarcerated populations, and increased access to services in areas with provider shortages. The three major “home telehealth” applications are: i) remote patient monitoring, ii) medication management, and iii) care transitions.

i. Remote Patient Monitoring

Remote patient monitoring (RPM) technologies are used to more closely monitor a patient’s health condition in their home. Using a variety of integrated or stand-alone RPM devices, up-to-date information on patients’ chronic disease and/or post-acute care status (including vital signs, heart rate, blood glucose levels, medication management, mental health, physical and cognitive fitness) and other data can be transmitted to family caregivers, providers, and other third parties. Clinicians or other properly trained individuals can then intervene by providing coaching or adjusting the course of treatment.

ii. Medication Management

Medication management technologies can assist patients and caregivers with obtaining proper medication information, patient education, medication organization, dispensing, and dose reminders, as well as safeguard against an overdose. A technology can potentially provide one or more of the following functions to an individual patient:

- Fill: provides patient with information and/or instructions about the drug
- Remind: reminds patients to take medications – audibly, visually, or both
- Dispense (e.g., in the home): automatically dispenses medications, usually at certain times/intervals
- Ingest: detects whether or not a patient has ingested his/her medications
- Metabolize: detects whether or not a patient has metabolized his/her medication
• Report: logs date and time when medication is taken and reports to clinician/caregiver
• Adjust: adjusts medication automatically if needed
• Reconcile: Screens current prescribed drugs and new physician orders for any potential adverse drug events

iii. Care Transitions

Care transitions technologies are used to improve the outcome of a patient’s transition from a hospital or facility to home by using specific information about the patient and the provider/s of medical services to help reduce re-admission. These technologies often utilize software applications that incorporate initial patient data at the time of transition along with new data post-transition to determine the most appropriate services and supports needed for a successful transition and to continually assess the patient’s progress.

Purpose of White Paper

This paper focuses on home telehealth applications and seeks to promote its benefits, such as cost savings and improved patient satisfaction, and to promote its adoption by payers, such as Medicare, Medi-Cal, and private insurance.
Current Telehealth Policies and Reimbursement

**Medicare:** Partial Medicare reimbursement for telehealth services was authorized in the Balanced Budget Act (BBA) of 1997. The narrow scope of this reimbursement prompted efforts toward expansion and revision of the Medicare reimbursement regulations. The Benefits Improvement and Protection Act of 2000 (BIPA) included amendments to the Social Security Act and removed some of the prior constraints, yet maintained substantial limitations related to geographic location, originating sites, and eligible telehealth services. As a result, Medicare currently limits reimbursement to services such as a live face-to-face encounter between a specified health professional and a patient, and limits the eligible patients to those residing in specific health facilities in rural areas.

Medicare does not provide coverage or payment for home telehealth services. Current law does not permit the substitution or use of a telecommunications system or other similar technology to provide any covered home health services paid under the home health benefit.

**Medicaid:** Federal Medicaid law does not recognize telehealth as a distinct service, but reimbursement for Medicaid services is one of the options states have as a cost-effective alternative to the more traditional ways of providing medical care. Unlike Medicare, most state Medicaid programs provide reimbursement for costly health care-related transportation, providing an added incentive to usher in telehealth. Currently, 27 state Medicaid programs acknowledge at least some reimbursement for telemedicine services. These states’ reimbursement policies, however, are mostly limited to telemedicine, such as live face-to-face encounters, and other services that are already a covered benefit when provided in-person. The result is an exclusion of reimbursement for innovative care delivery models using new technology, thus inhibiting the adoption of home telehealth and the realization of its benefits.

Exceptions to this exclusion exist and Pennsylvania and New York are model states that have led the path in establishing home telehealth policies and reimbursement protocols. While they differ in scope and structure, both programs have incorporated new home telehealth care modalities into their Medicaid and other state programs serving older adults and persons living with chronic conditions. It is worth noting that Pennsylvania established its program on a cost-neutral basis. Below is a brief summary of these two programs as well as those of South Carolina, South Dakota, and Ohio:

**Pennsylvania** On October 1, 2009, the Pennsylvania Office of Long-term Living released final regulations for the state’s “TeleCare” program available to residents age 60 and older. The program covers more home telehealth services than any other state’s program.

Pennsylvania began its program as a Medicaid-waiver demonstration in September 2007, and then received CMS approval to include it in the state’s waiver program in July 2008. The state also extended eligibility for the program beyond its Medicaid-eligible consumers to its “Options” program, which involves a sliding scale for share of cost based on income.
Services included under PA’s TeleCare include remote patient monitoring, activity and sensor monitoring, (PERS), and medication dispensing and management. One registered nurse in-person visit is included in the health status measuring and monitoring fees. Eligible providers include Medicare-certified home health agencies, durable medical equipment providers, personal care/homemaker providers, pharmacies, and hospitals depending on the technology being deployed.

Reimbursement is provided for installation and monthly fees and is managed by Area Services on Aging:

- **Health Status Measuring and Monitoring**: $90 installation, $10/day
- **Activity and Sensor Monitoring**: $200 installation, $80/month
- **Medication Dispensing and Monitoring**: $50/month

**New York**  
In 2007 the New York legislature enacted the Medicaid “Home Telehealth” program on an 18-month pilot basis. The program includes remote patient monitoring, patient education, medication management, equipment maintenance, and review of patient trends and/or changes in patient condition and identification of problematic changes requiring intervention. Eligible providers are home health agencies and long-term home health programs that are community based or affiliated with a nursing home or hospital.

In October, 2009 NY adopted the Home Telehealth program as part of its standard Medicaid program and instituted the following reimbursement rates depending on the degree to which technologies are integrated with point of care software and electronic medical records:

- **Tier 1**: $8.88/day – FDA approved class II device capable of interoperability with point of care (POC) software
- **Tier 2**: $10.19/day – Interconnected with POC Software
- **Tier 3**: (rate to be developed) – Interconnected with EMR and statewide health information network
- **Installation Fee**: Providers can bill for a one-time installation fee of $50 for each telehealth user.

**South Carolina**  
South Carolina’s telemonitoring service started as a reimbursed SC Choice waiver service in February 2009. The Telemonitoring service is available to Community Choices participants to maintain and promote their health status through medical telemonitoring of body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information.

**Conditions of Participation - Providers**

1. Providers must have equipment that records at a minimum the participant’s body weight, blood pressure, oxygen saturation, blood glucose levels, and basic heart rate information. All agencies must also have nursing personnel and health care professionals able to carry out the duties of the service described below.
2. Providers must agree to participate in all components of the Care Call monitoring and payment system and have the capability to receive and respond to authorizations for service in an electronic format.

3. Providers must have at least one (1) year of experience or otherwise demonstrate competency in the provision of this service.

Conditions of Participation – Community Choices Waiver Participants

Community Choices waiver participants must meet the following criteria in order to be considered for the telemonitoring service:

- Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and/or Congestive Heart Failure; and

- Have a history of at least two hospitalizations and/or emergency room visits in the past 12 months; and

- Have a primary care physician that approves the use of the telemonitoring service and is solely responsible for receiving and acting upon the information received via the telemonitoring service; and

- Be capable of using the telemonitoring equipment and transmitting the necessary data or have an individual available to them that is capable of utilizing the telemonitoring equipment and transmitting data to the telemonitoring provider.

- DME/PERS Service: $36 per month
- DME/PERS Installation: $36 one-time
- Telemonitoring: $10 per day (no maximum number of days per year)

South Dakota The SD Elderly waiver expires fall 2011. Staff is now reviewing the current waiver and developing a renewal waiver application, which may or may not change program parameters.

- Specialized Medical Equipment and Supplies: Not to exceed $250 per month including Medication Dispensers and Telehealth Equipment
- Telehealth Installation: $30
- Telehealth Clinical Monitoring: $150 - $217 per month
- Telehealth Nurse Assessment: $36.84 per hour
- PERS Service: $45 per month
Ohio One recent example where government has established new policies to advance the utilization of telehealth is Ohio, which has recently proposed legislation with reimbursement options for telehealth services provided to the developmental disability population enrolled in the state Medicaid program. The proposal is currently under consideration by the Centers for Medicare and Medicaid (CMS) as a Medicaid Waiver amendment, and is expected to be available to Ohio providers in January 2011.

Under the waiver proposal, “remote monitoring” is defined as the monitoring of an individual in his or her residence by staff using one or more of the following systems: live video feed, live audio feed, motion sensing system, radio frequency identification, web-based monitoring system, or other device approved by DODD. The proposal additionally requires that the remote monitoring service must 1) ensure health and safety; and 2) must be used to reduce or replace the amount of homemaker/personal care (HPC) services an individual receives.

DODD Proposed Remote Monitoring Reimbursement Rates:

- RM Service Rate Model 1 is $6.47 per hour/per site when “natural” (unpaid) backup support is available;
- RM Service Rate Model 2 is $9.83 per hour/per site when a HPC Provider is providing the backup support (under this model, remote monitoring service would switch to HPC when backup support is contacted);
- RM Equipment reimbursement is capped at $10,000 statewide annually; separate from RM service reimbursement.

1. When two or more individuals share Remote Monitoring Equipment at a residence, they are required to lease equipment that is shared.
2. Remote Monitoring Equipment that is for the specific use of a particular individual may be leased or purchased by that individual.

Private Insurance: As with Medicaid, regulations for telehealth reimbursement by private insurers are set by the states. Five states have enacted laws requiring that services provided via telemedicine must be reimbursed if the same service would be reimbursed when provided in person. Some insurance programs cover specific telehealth services, e.g., behavioral health and at least four major health insurers -- Aetna, Humana, UnitedHealth Group and WellPoint's Anthem Blue Cross in California -- are conducting trials or have announced plans for programs that allow patients to wirelessly and remotely send data, such as weight, blood pressure and other vital sign readings, to a health care professional for tracking and follow-up purposes. Similar to Medicaid, however, few private insurers currently provide home telehealth services either voluntarily or due to state insurance regulations.
A History of California’s Telehealth Initiatives

The Telemedicine Development Act of 1996 (SB 1665) imposed several requirements governing the delivery of health care services through telemedicine, as defined including various requirements in regard to the provision of, or payment for, telemedicine services.

SB 922 amended the Telemedicine Development Act of 1996 to exclude from the definition of telemedicine, telephone conversations and electronic mail messages between a health care practitioner, as defined, and a patient.

AB 116 included that the provisions of law regulating telemedicine apply to the practice of a dentist, a podiatrist, a psychologist, a marriage and family therapist, and a clinical social worker.

AB 354 until January 1, 2009, authorizes under the Medi-Cal program, to the extent that federal financial participation is available, “teleophthalmology and teledermatology by store and forward,” as defined.

Executive Order S-12-06 allocated $240 million to achieve full information exchange between health care providers and stakeholders within ten years.

Executive Order S-23-06 established a broadband task force to promote broadband access and usage.

AB 329 authorizes the Medical Board of California to establish a pilot program to expand the practice of telemedicine, and would authorize the board to implement the program by convening a working group. The bill would specify that the purpose of the pilot program would be to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases and delivering other health information.

AB 1224 defines the practice of optometry as including the treatment of primary open-angle glaucoma with the participation, as specified, of a collaborating ophthalmologist. Makes a licensed optometrist subject to “interactive” telemedicine provisions and would define collaborating ophthalmologist for purposes of his or her participation in treating primary open angle glaucoma.

AB 234 imposes a 125-hour limitation on experience earned providing personal psychotherapy services via telemedicine, as defined, and would modify the definition of professional enrichment activities for these purposes. Executive Order S-06-07 advances the adoption of health information technology, increases transparency of quality and pricing information, and promotes quality and efficiency of health care services.

AB 2120 extends authorization of the Medi-Cal program, to the extent that federal financial participation is available, “teleophthalmology and teledermatology by store and forward,” as defined until January 1, 2013.

(Note: all legislation above relates to telemedicine and no legislation has been enacted relating to home telehealth or broader telehealth applications)
The Benefits of Telehealth

Why Telehealth Is Needed?

The recent focus on improving post-acute care transitions (the process by which a patient moves from hospital to home or other settings) is being driven by an interest in reducing hospital readmissions. The United States has an 18% rate of hospital readmissions within 30 days of discharge—and as many as 76% of these are preventable.

Reducing readmissions rates has become a high priority for policymakers and payers seeking to improve health care quality and contain costs. Researchers estimate that the national fiscal impact to Medicare as a result of unplanned hospital readmissions was $17.4 billion in 2004.\textsuperscript{vii} Re-hospitalization also appears to increase the risk of health complications, resulting in greater functional and cognitive impairments for patients.\textsuperscript{viii}

Medication non-adherence contributes to 33\%-69\% of medication-related hospital admissions and 23\% of all nursing home admissions.\textsuperscript{ix} Moreover, the New England Healthcare Institute estimates that $290 billion of health care expenditures could be avoided each year if medication adherence were improved.\textsuperscript{x}

In 2009, the Medicare Payment Advisory Council (MedPAC) concluded that a large proportion of re-hospitalizations is potentially preventable and recommended improving post-acute care transitions processes.

The VHA Study

Many demonstration and pilot projects aimed at demonstrating the effectiveness of telehealth have been completed or are underway, but by far the most comprehensive study to date was performed by the Veterans Health Administration (VHA), incorporating four years of data on over 17,000 patients.

Between July 2003 and December 2007, the VHA introduced a national home telehealth program, called the Care Coordination/Home Telehealth (CCHT). Its purpose was to coordinate the care of veteran patients with chronic conditions and avoid their unnecessary admission to long-term institutional care. An internal VHA needs assessment in 2002 outlined the scope for CCHT implementation and recommended an original population target of 21,000 to 32,000 chronic care management patients. Additional opportunities were identified to expand CCHT to cover acute care management and health promotion/disease prevention. Thirty-two percent of the veteran population VHA treats lives in rural areas which poses challenges in providing them with timely access to specialty care. Therefore, VHA’s CCHT program was charged with ensuring it offered support to care for veterans needing...
Routine analysis of data obtained for quality and performance purposes from a cohort of 17,025 CCHT patients shows the benefits of a 25 percent reduction in numbers of bed days of care, 19 percent reduction in numbers of hospital admissions, and mean satisfaction score rating of 86 percent after enrollment into the program. The cost of CCHT is $1,600 per patient per annum, substantially less than other NIC programs and nursing home care.

**Table 1**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Patients</th>
<th>Utilization Decrease Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>8,954</td>
<td>20.4</td>
</tr>
<tr>
<td>Hypertension</td>
<td>7,447</td>
<td>30.3</td>
</tr>
<tr>
<td>Chronic Heart Failure</td>
<td>4,089</td>
<td>25.9</td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease</td>
<td>1,963</td>
<td>20.7</td>
</tr>
<tr>
<td>Posttraumatic Stress Disorder</td>
<td>129</td>
<td>45.1</td>
</tr>
<tr>
<td>Depression</td>
<td>337</td>
<td>56.4</td>
</tr>
<tr>
<td>Other Mental Health Condition</td>
<td>653</td>
<td>40.9</td>
</tr>
<tr>
<td>Single Condition</td>
<td>10,885</td>
<td>24.8</td>
</tr>
<tr>
<td>Multiple Conditions</td>
<td>6,140</td>
<td>26.0</td>
</tr>
</tbody>
</table>

**Table 2**

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Patients</th>
<th>Utilization Decrease Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>9,880</td>
<td>29.2</td>
</tr>
<tr>
<td>Rural</td>
<td>6,782</td>
<td>17</td>
</tr>
<tr>
<td>Highly Rural</td>
<td>294</td>
<td>50.1</td>
</tr>
<tr>
<td>Unknown</td>
<td>60</td>
<td>101</td>
</tr>
</tbody>
</table>

**Table 3**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Number of Patients</th>
<th>Utilization Decrease Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>20-29</td>
<td>31</td>
<td>12</td>
</tr>
<tr>
<td>30-39</td>
<td>162</td>
<td>9.7</td>
</tr>
<tr>
<td>40-49</td>
<td>832</td>
<td>30</td>
</tr>
<tr>
<td>50-59</td>
<td>4,402</td>
<td>26.2</td>
</tr>
<tr>
<td>60-69</td>
<td>5,008</td>
<td>22</td>
</tr>
</tbody>
</table>
To achieve these results VHA employed a range of coordinated care strategies. After a patient was enrolled into the program, his or her care coordinator selected the appropriate home telehealth technology, gave the required training to the patient and caregiver, reviewed telehealth monitoring data, and provided active care or case management (including communication with the patient’s physician). Typically, an individual care coordinator managed a panel of between 100 and 150 general medical patients or 90 patients with mental health–related conditions.

Dependent upon a patient’s underlying chronic condition and guided by the enrollment assessment, their care coordinator selected the appropriate vital signs, other objective parameters (e.g., blood glucose), or disease management data to acquire from the home for ongoing monitoring and disease management purposes. The care coordinator then decided which technology was best-suited to collect these data.

VHA established national contracts for commercial-off-the-shelf devices for CCHT and developed a technology algorithm, that is based upon a patient’s health needs, the complexity of disease/condition, and ability to use technology, to determine which CCHT device would be most suitable and cost-effective to use for each individual patient.

Messaging devices presented disease management protocols, which contained text-based questions for patients to answer. These DMPs required responses from patients that helped to assess their health status and disease self-management capabilities. Biometric devices recorded and monitored vital sign data. Videophones and videotelemonitors supported audio–video consultations into the home that replicated face-to-face examinations.

**The following examples illustrate the improved outcomes and cost savings being achieved by telemedicine and telehealth programs:**

- Home monitoring of chronic diseases is reducing hospital visits by as much as 50 percent by keeping patients stable through daily monitoring\(^{\text{xii}}\)
- The national average for re-admission to hospitals within 30 days following a heart failure episode is 20 percent. Telehealth monitoring programs have reduced that rate to less than 4 percent\(^{\text{xiii}}\)
- Timely provision of treatments that effectively reverse the consequences of a stroke have risen from 15 percent to 85 percent due to the availability of telestroke programs\(^{\text{xiv}}\)
Potential for California:
Telehealth in Medi-Cal Home Health Services

Based on the data produced by the VHA study and annual Medi-Cal data contained in OSHPD reports it is possible to calculate potential savings if telehealth were widely adopted throughout home health services in the Medi-Cal program. Table 4 demonstrates a potential savings of over $16 million in home health services for only the four patient conditions identical to the conditions assessed in the VHA study. These four conditions account for approximately 22% of the total Medi-Cal population; thus it can be inferred that the savings below only account for approximately 22% of total potential savings in Medi-Cal if home telehealth is fully adopted.

### Table 4

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>NUMBER OF MEDI-CAL PATIENTS*</th>
<th>NUMBER OF DISCHARGES TO HOSPITALS**</th>
<th>PERCENT DECREASE IN HOSPITAL DISCHARGE (BASED ON VHA STUDY)</th>
<th>MEDI-CAL SAVINGS***</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>4,496</td>
<td>273</td>
<td>20.4</td>
<td>$4,533,812</td>
</tr>
<tr>
<td>CHF</td>
<td>7,184</td>
<td>463</td>
<td>25.9</td>
<td>$7,243,184</td>
</tr>
<tr>
<td>COPD</td>
<td>4,251</td>
<td>258</td>
<td>20.7</td>
<td>$4,286,265</td>
</tr>
<tr>
<td>Mental Health</td>
<td>544</td>
<td>33</td>
<td>40.9</td>
<td>$547,722</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>16,475</strong></td>
<td><strong>1,000</strong></td>
<td><strong>40.9</strong></td>
<td><strong>$16,610,984</strong></td>
</tr>
</tbody>
</table>

* Based on total 2009 OSHPD data, including Medi-Cal and Medicare patients, multiplied by % of Medi-Cal patients to total patients (11.74%)
** Number of discharges to hospital sourced from 2009 OSHPD data, and prorated based on ratio of patients with specified condition to total HH patients Medi-Cal + Medicare, and then multiplied by 11.74% ratio of Medi-Cal patients to total patients.
*** Assuming average price of an inpatient stay of $20,858 based on 2009 OSHPD data

If applied to the total home health population of Medi-Cal and Medicare patients in California (617,066) and their total number of discharges to hospitals (37,474) then the total potential annual savings, based on an average 19 percent reduction in hospitalizations and an assumption that 60% of all Medicaid/Medicare readmissions would be appropriate for telehealth intervention, is $379,873,488.

**In addition to the potential savings, a wider deployment of telehealth in California could produce other benefits such as:**

- Empower patients to play an active role in their healthcare through health-management tools
- High patient satisfaction (VHA study resulted in an 86% patient satisfaction rating)
- Rural clinicians can more easily obtain continuing education
- Rural clinicians can more easily consult with specialists
- Sense of security and prolonged independence
- Enables dispatching of timely and appropriate services resulting in improved caregiver efficiency
- Early and preventive interventions
- Reduced transportation costs
Moving Forward

**Roadblocks to Adoption**

Current coverage and reimbursement for telehealth might best be described as a patchwork of services and payers with varying service coverage and payment restrictions between different health systems. Some reimbursement requirements specify covered services at certain locations; others limit the type of service to certain circumstances. Most experts believe that telehealth will not be able to reach full potential without comprehensive reimbursement.

*Most experts believe that telehealth will not be able to reach full potential without comprehensive reimbursement.*

**Other Inhibitors of Expansion**

While coverage and reimbursement are significant issues to the optimal implementation of telehealth, the California HealthCare Foundation and others cite additional barriers such as the complexity and initial cost of technology, the lack of sustainable business models, the need for program funding, the need for updated provider licensing regulations, and the need to increase consumer demand.

**Conclusions and Recommendations**

Telehealth applications are now available for services covering the entire spectrum of healthcare, from managing chronic disease through the use of home monitoring systems to supporting critically ill patients in emergency departments and intensive care units. Research and demonstration projects indicate that telehealth applications applied across the spectrum of healthcare services will result in substantial improvements. Program experience indicates that major savings in healthcare costs and subsequent social service support can be achieved across the spectrum of healthcare services.

Many state’s Medicaid programs now cover certain teledmedicine services, as long as those services were previously covered if provided in person. New technologies, however, have made possible innovative, effective, and cost-saving methods of health care delivery, but these home telehealth services have only being adopted in a few select states. In these situations, government involvement is usually the best option and often the only option.

The realization of benefits from widespread home telehealth is caught in a chicken and egg scenario; where payer sources don’t see the need to reimburse for telehealth services until it is more widely adopted, but the wide adoption of telehealth is dependent on the reimbursement of costs to providers.
California’s legislature and administration should follow the lead of Pennsylvania and New York and quickly develop policies that will allow Medi-Cal to cover home telehealth services. This could easily be initiated by a pilot project concluding with a review of cost savings and consumer outcomes. Reimbursement amounts for the pilot project could be based on those in other states and then adjusted depending on the concluding reports. If done, California stands to save millions of dollars, increase patient satisfaction, and enjoy peripheral benefits such as quicker adoption by private insurance and increased economic activity in the growing health technology industry.

**California Policy Recommendations:**

**Medi-Cal Home Telehealth:** California’s legislature and administration should follow the lead of Pennsylvania, New York, South Carolina, South Dakota and other states by revising policies to allow Medi-Cal reimbursement of home telehealth services. This can readily be accomplished by amending California’s Nursing Facility/Acute Hospital Medicaid Waiver to add home telehealth as an authorized service modality in the 5-year renewal application now being drafted for submission to the Center for Medicare and Medicaid Services (CMS) later this year. It is important to note that this can be developed on a cost-neutral/cost-savings basis to Medi-Cal. The state could choose to pursue the waiver amendment by beginning with a demonstration project which concludes with a review of cost savings and consumer outcomes. Reimbursement rates for the demonstration project could be based on those used in other states and adjusted based on the project’s findings. If adopted into Medi-Cal, California stands to save millions of dollars, increase patient/consumer satisfaction, and enjoy peripheral benefits such as improved caregiver efficiency, reduction in preventable acute episodes, and increased economic activity in the growing health technology industry.

**Insurance Plan Coverage of Home Telehealth:** California policy makers should pursue reimbursement of home telehealth by insurance plans operating in California. Through statutory and/or regulatory measures, California can be a leader in the widespread insurance reimbursement of telehealth technologies, benefiting millions of people with great impact for reduced health care costs.
Endnotes:

i Center for Telehealth and E-Law, http://www.telehealthlawcenter.org/?c=117

ii CAST Analysis of State Payment for Aging Services Technologies (ASTs), S. Peifer, CAST and Leading Age, January 2011


v More Insurers Open to Remote-Monitoring for Care of Heart Patients, Johnson, Wall Street Journal, 7/27


vii Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare


