Home Telehealth in California
Benefits & Opportunities
April 2012
# Table of Contents

## Introduction
- Home Telehealth: What is it?
- Purpose of White Paper
- Current Telehealth Policies and Reimbursement
- A History of California’s Telehealth Legislation
- California Telehealth Advancement Act of 2011

## The Benefits of Home Telehealth
- The VHA Study
- Telehealth in Medi-Cal Home Health Services
- Potential for California

## Moving Forward
- California Policy Opportunities for Home Telehealth Adoption
- Conclusion
Introduction

Home Telehealth: What Is It?
As recently defined by the Telehealth Advancement Act of 2011 in Section 2290.5 of the California Business and Professions Code, “telehealth” means “the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.”

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/inter vals.
• 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.

What is the Difference Between Telemedicine and Telehealth?
Telemedicine often refers only to the provision of clinical services while the term telehealth can refer to clinical and non-clinical services such as medical education, administration, and coordination. There are two main approaches for providing telemedicine services: live face-to-face encounters between patient and health professional via real-time image technology, and “store and forward“ which allows a provider or technician at the patient site to capture diagnostic information using clinical instruments and send the digital image of the information to a clinician at a remote site. This paper focuses on the broader telehealth technologies and introduces the term “home telehealth,” which refers to telehealth applications in the patient’s home that are monitored and managed by home health professionals.
**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 2-way video encounters, and other services that are already a covered benefit when provided in-person.

However, several state Medicaid home telehealth programs have been developed in recent years. At least eight states now provide Medicaid reimbursement for home telehealth/remote monitoring services. Pennsylvania, New York and more recently Colorado are model states that have led the path in establishing home telehealth policies and reimbursement protocols. While they differ in scope and structure, these state 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 programs as well as those of South Carolina and South Dakota:

**Colorado**

The most recent example where a state government has established new policies to advance the utilization of telehealth is Colorado, which recently enacted a reimbursement program for home telehealth services in Medicaid through a new “Home Health Telehealth Services (HHTS) program.” Colorado’s first HHTS visit was billable on February 1, 2012. This home telehealth service allows a home health agency to collect clinical information via electronic transmission from the client’s home to the home health agency for evaluation and management. The purpose of providing telehealth services is to manage and monitor the care of clients whose medical needs can be appropriately and cost-effectively met at home, through the monitoring of data and early intervention. HHTS is provided under the Home Health Benefit through agencies that have opted to provide the telehealth service.
**Eligibility:** All Medicaid eligible clients who receive home health services from a provider who has opted to provide telehealth services and meet the following criteria are eligible for Colorado HHTS:

1. Have one or more of the following diagnoses: Congestive Heart Failure (CHF), Chronic Obstructive Pulmonary Disease (COPD), Asthma; or Diabetes.
2. Client must require frequent and on-going monitoring/management of their disease.
3. Client’s home environment must be compatible for the use of the equipment.
4. Client or caregiver must be willing and able to comply with the self vital-sign monitoring.

**Requirements (partial listing):**
- HHTS is available to clients only after the Home Health Agency has received prior authorization.
- The information and data collected remotely will be transmitted through electronic information processing equipment from the client to the home health provider. The transmission of the data shall meet HIPAA compliance standards.
- All data collected must be reviewed by a registered nurse, or licensed practical nurse consistent with state law, within 24 hours of receipt of the ordered transmission.
- Any planned interventions must be overseen by the client’s designated nurse.
- Monitoring equipment shall have the capability to measure any changes in the monitored diagnoses and meet specified standards.
- The Home Health Agency shall make at least one home health nursing visit every 14 days to a client using Home Health Telehealth services.

**Reimbursement:** Colorado’s reimbursement rates are $9.45 per encounter for both acute and long-term home health telehealth encounters and $50 for equipment setup. One encounter may be billed per patient per day, up to 31 encounters per month (i.e., maximum of $292.95 per month). One setup may be billed per patient per agency.

**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 – Community Choices Waiver Participants

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

1. Have a primary diagnosis of Insulin Dependent Diabetes Mellitus, Hypertension, Chronic Obstructive Pulmonary Disease, and/or Congestive Heart Failure; and
2. Have a history of at least two hospitalizations and/or emergency room visits in the past 12 months; and
3. 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
4. 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)
The SD Elderly Waiver provides for the purchase, installation and monthly reimbursement for home telehealth services as follows:

- 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

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.

The California Telehealth Advancement Act of 2011 (see below) further enables the use of telehealth by health plans. These provisions do not require the use of telehealth if inappropriate, nor do they change plans’ decision making ability regarding care authorizations and covered services. Rather, they make telehealth a viable tool available to plans and providers.
## A History of California’s Telehealth Legislation

<table>
<thead>
<tr>
<th>Year</th>
<th>Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996</td>
<td><em>The Telemedicine Development Act of 1996 (SB 1665)</em> 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.</td>
</tr>
<tr>
<td>1997</td>
<td><em>SB 922 amended the Telemedicine Development Act of 1996</em> to exclude from the definition of telemedicine, telephone conversations and electronic mail messages between a health care practitioner, as defined, and a patient.</td>
</tr>
<tr>
<td>2003</td>
<td><em>AB 116</em> 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.</td>
</tr>
<tr>
<td>2005</td>
<td><em>AB 354</em> 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.</td>
</tr>
</tbody>
</table>
| 2006 | *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. |
| 2007 | *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. |
| 2008 | *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. |
| 2011 | *AB 415* enacts the California Telehealth Advancement Act of 2011, making the most significant gains in California statutes since the enactment of the Telemedicine Act of 1996. |
California Telehealth Advancement Act

Until 2011, all legislation relating to telehealth in California has been specifically with regard to “telemedicine,” not telehealth. AB 415 (Logue), the “Telehealth Advancement Act of 2011,” enacted the most significant changes to California’s statutes since the 1996 Telemedicine Act, completely recasting the law’s provisions to speak to broader “telehealth” utilization. It updates the legal definitions of telehealth, removes barriers, streamlines approval processes for telehealth services, and supports the expansion of telehealth services statewide.

The Act creates better parity between health care services delivered via telehealth and delivered in person, and further distinguishes telehealth as a mode of delivering services. Among its most important provisions is expanding the list of providers eligible to utilize telehealth for purposes of Medi-Cal and insurance plans operating in California. Under the previous law, only the following health professionals could provide services through telemedicine:

- Physicians
- Podiatrists
- Marriage, family and child counselors
- Optometrists (in limited scope)

The Telehealth Advancement Act made these professionals eligible to use telehealth and expanded the list to include all health care professionals licensed by the State of California:

- Pharmacists
- Physician assistants
- Dental hygienists
- Occupational therapists
- Audiologists
- Psychologists
- Naturopaths
- Surgeons
- Clinical psychologists
- Dentists
- Nurse practitioners
- Registered nurses
- Physical therapists
- Speech and language pathologists
- Licensed vocational nurses
- Osteopaths

The expanded list of eligible telehealth providers is especially important to the adoption of home telehealth, since such applications often involve licensed nurses, therapists, pharmacists and others providing care in residential and community settings. Also important to home telehealth utilization is the Act’s removal of limits on allowable settings for telehealth, allowing services delivered via telehealth to be covered (pursuant to payer contracts with providers), regardless of where it takes place.

To be clear, the Telehealth Advancement Act of 2011 does not mandate the use or reimbursement of any telehealth services by public or private payers. Covered services, and the locations of their delivery, are negotiated in contracts between health plans and providers, and in public insurance programs including Medi-Cal. However, the Act paves the way for expanded use of telehealth, including home telehealth, in California and is a major policy step forward.\textsuperscript{xix}
Why Is Home Telehealth 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 27% 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. Re-hospitalization also appears to increase the risk of health complications, resulting in greater functional and cognitive impairments for patients.

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

In 2009, the Medicare Payment Advisory Council (MedPAC) concluded that a large proportion of re-hospitalizations are 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

continued on page 13
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>Post traumatic 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>
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<tr>
<td>Single Condition</td>
<td>10,885</td>
<td>24.8</td>
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<tr>
<td>Multiple Conditions</td>
<td>6,140</td>
<td>26.0</td>
</tr>
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</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>
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<tr>
<td>Unknown</td>
<td>60</td>
<td>101</td>
</tr>
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</table>

Table 3

<table>
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<tr>
<th>Age Range</th>
<th>Number of Patients</th>
<th>Utilization Decrease Percent</th>
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</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>
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</table>
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 care in rural areas.

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 telehealth programs:

• Home monitoring of chronic diseases is reducing hospital visits by as much as 50 percent by keeping patients stable through daily monitoring
  
• 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 four percent
  
• 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
Potential for California: Home 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 Discharged 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></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.

Moreover, an analysis conducted in 2011 with applicability to Medicaid beneficiaries in general (not only those receiving home health care) shows remarkable cost savings opportunities for even just one of the four disease groups – chronic heart failure (CHF). It is estimated that the use of telehealth for home monitoring of heart failure patients has the potential to produce savings in the Medi-Cal program of up to $929 million annually in the cost of care for the 107,000 beneficiaries living with CHF.

In addition to the potential savings, a wider deployment of home 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

California Policy Opportunities for Home Telehealth Adoption

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.

However, 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 home telehealth is dependent on its approval as an allowable service modality and customary reimbursement of costs to providers.

Current coverage and reimbursement for telehealth, including home telehealth and similar residence-based eCare technologies might best be described as a patchwork of services and payers with varying service coverage and payment restrictions between different health systems. Most experts believe that telehealth will not be able to reach full potential without becoming a customary component of public health care programs and health plan benefit packages with corresponding reimbursement.

The following are three current California policy opportunities for leveraging home telehealth and other eCare technologies to achieve better care coordination, better health outcomes and lower costs.

Most experts believe that telehealth will not be able to reach full potential without becoming a customary component of public health care programs and health plan benefit packages with corresponding reimbursement.

Dual Eligible Integration Project

The California Department of Health Care Services’ (DHCS) Dual Eligible Integration Pilot Project, authorized by the federal Patient Protection and Affordable Care Act (ACA), presents an important opportunity for policy innovations that demonstrate the benefit of technology-enabled care (“eCare”) to help the State achieve personalized and coordinated health and long-term care services and supports.

The “dual eligibles” are those persons eligible for both Medicare and Medi-Cal. 70 percent (770,042) are 65 or older. They are the most chronically ill and costliest of all Medicaid beneficiaries - representing 15 percent of Medicaid enrollees and nearly 40 percent of the program’s spending. The majority of dual eligible costs pay for long-term services and supports not covered by Medicare. In California, 54% of duals have a cardiovascular disease, 52% have a psychiatric illness, 28% have a disease of the central nervous system, and 22% have diabetes.

We applaud the inclusion of language in California’s Dual Eligible Demonstration Request for Solutions (RFS) that encourages the utilization of eCare technologies and requires applicants to describe how they propose to include such technologies (such as telehealth, remote health vitals and activity monitoring, care management technologies, medication compliance monitoring, etc.) in models of care. If substantially utilized with the dual eligible population and other Medi-Cal enrollees with
disease groups such as chronic heart failure, diabetes and COPD, home telehealth could result in $1 billion of savings for the State.iii

Contained in his 2012-13 budget proposal, Governor Brown’s Coordinated Care Initiative would expand the number of Dual Eligible Project pilot counties from four to eight or 10 in its first year, and expand to all 58 counties within three years. In addition, the Governor’s budget proposes a statewide expansion of Medi-Cal managed care, beginning in June 2014xv. The statewide scope of these reform initiatives creates an unprecedented California policy opportunity to leverage care technologies to better meet the objectives of improved care coordination and health outcomes, increase staff efficiencies, and reduced healthcare costs. AgeTech California therefore recommends that utilization of eCare modalities be required in participating plans’ approved care package offerings.

Health Home Option
Section 2703 of the ACA created a program designed to provide health homes for Medicaid recipients with chronic conditions and mental diagnosis. The act allows states to receive funding from CMS to reimburse home health providers. This provision of the ACA is designed to provide better coordinated care for beneficiaries with multiple conditions.xvi

DHCS received $1 million in planning funds to determine whether or not to pursue implementation of the program. The Department recently completed an assessment which proposes seven potential health home model options, and two sub-options. DHCS has not decided which option to ultimately pursue, but is planning a deeper assessment of certain options which would result in the greatest savings to the State.

As the Department continues the assessment of options, inclusion of tech-enabled care criteria could assist in designing a service model option that is more cost effective and beneficial to the recipient. Technologies such as remote patient monitoring, if deployed in health home arrangements, could be networked with current health information technology (HIT) infrastructure to provide support throughout the enrollment, treatment and payment processxvii, xviii

AgeTech encourages the inclusion of tech-enabled models of care coordination in the State’s Health Homes’ planning and analysis considerations, and that such models be deployed should the program move forward.

Medi-Cal Home and Community Based Services
California should follow the lead of Pennsylvania, New York, Colorado and several other states by revising policies to allow Medi-Cal reimbursement of home telehealth services. This could be accomplished by amending California’s Nursing Facility/Acute Hospital Medicaid Waiver to add home telehealth as an authorized service modality, or adding it as an authorized Medicaid state plan service eligible for reimbursement. Statutory revisions made by the California Telehealth Advancement Act of 2011 cleared regulatory hurdles previously making such changes difficult in California.

Each state has taken a slightly different approach in creating a home telehealth/remote monitoring reimbursement component to their Medicaid coverage, either through pursuing CMS waivers or beginning with pilot projects. California could choose to pursue home telehealth reimbursement in the context of home and community based services by beginning with a demonstration project followed by a review of cost savings and consumer outcomes before full implementation.
Conclusion

California is well positioned to lead the coming revolution in technology-enabled personalized and continuous care to keep seniors healthy and independent and reduce health care costs through better chronic disease management. California has the nation’s largest population of older adults. It also has a world-leading technology industry and innovation culture, world-class academic and research institutions, and top aging-services and homecare provider organizations. California’s health and long-term service and support reforms currently underway, together with the removal of policy barriers and foundational telehealth provisions enacted by the California Telehealth Advancement Act of 2011, present unprecedented opportunities to incorporate the use of home telehealth and other eCare technologies in public health programs and health plans’ covered services. Home care and aging service organizations are well suited to lead the deployment of technology-enabled care in partnership with health plans and public programs. We cannot afford to miss this opportunity to leverage technology to better manage the health and wellness of older Californians while stretching limited resources.

About AgeTech California
AgeTech California was established to promote the use of advanced health and wellness technologies by aging services and home care providers throughout California. Its primary focus is on technologies that enable older Californians’ aging in “connected independence” with safety and security, personal health maintenance, successful management of chronic disease, early detection of illness, and prevention of acute episodes. Such technologies include telehealth, electronic health records, sensor telemonitoring, remote medication management, safety technologies, and cognitive fitness among others that enable eCare and personal wellness while enhancing caregiving and cost efficiency. AgeTech is a programmatic partnership of Aging Services of California and the California Association for Health Services at Home (CAHSAH).

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


State Option to Provide Health Homes for Enrollees with Chronic Conditions, http://dhhs.nv.gov/HealthCare/Docs/NVPolicyPapers/Section 2703 Health Homes.pdf

Continua Health Alliance, The Affordable Care Act offers funding for State Medicaid Programs to Adopt “Health Homes” for Enrollees with Chronic Conditions.


AgeTech Advisory Council

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Accredited Home Health Services
Woodland Hills, Calif.

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Eskaton
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UCLA Center on Aging
Los Angeles, Calif.

Kathleen Sullivan
Dignity Health
Santa Maria, Calif.

AgeTech California
Executive Committee

Joanne Handy
President and CEO
Aging Services of California
1315 I Street, Suite 100
Sacramento, CA 95814
Phone: (916) 469-3363
Email: jhandy@aging.org

Dean Chalios
President
California Association for Health Services at Home
3780 Rosin Court, Suite 190
Sacramento, CA 95834
Phone: (916) 641-5795
Email: dchalios@cahsah.org
Promoting Technology-Enabled Care for Older Californians