2014 TELEMEDICINE TASK FORCE
FINANCE AND BUSINESS MODEL ADVISORY GROUP

The Telemedicine Task Force Clinical Advisory Group has identified four innovative telehealth use cases. The following table outlines the use cases and includes discussion items regarding financial and business model challenges of the use cases and potential solutions.

Innovative Telehealth Use Cases	Innovative Telehealth Use Cases Internal Considerations to Carriers	Timeframes to Implement	Other
1. Improve transitions of care between acute and post acute settings through telehealth 2. The use of telehealth to manage hospital Prevention Quality Indicators 3. Incorporate telehealth in hospital innovative payment and service delivery models through ambulatory practice shared savings programs 4. Require payor-based patient centered medical home programs to factor in reimbursement for telehealth by primary care providers and specialists 5. Telehealth in hospital emergency departments and during transport of patients 6. Public health screening, monitoring and documentation with data exchange 7. Telehealth in schools for asthma management, diabetes, childhood obesity, behavioral health, and smoking cessation 8. Telehealth for routine and high-risk pregnancies 9. Widespread deployment of telehealth for health care services connected through various technology applications , health care professionals, and/or the statewide health information exchange 10. Telementoring and teleproctoring for the expansion of skills	• Use existing coding? • Identify appropriate billing codes, discharge from hospital, what exists today and what would be required to support a future use case • New paradigm and skill set, evolving and centered on mid-level providers, different than traditional billing, rather would be a team effort, value-based purchasing, are these services bundled in • Who would provide service, hospitals, doctors, currently no boundaries around concept, physician group in hospital could coordinate transition to care, who gets paid and how much • If there are multiple entities that would bill, how would that be allocated; could be criteria regarding services provided, and allocation would be established internally • Improvement, are we looking	• New product development might be longer than a year, need to consider what providers need to be reimbursed for • Unique challenges for Maryland given our hospital payment system, CareFirst is localized, others function on more of a national level so difficult to implement State-specific • Medicaid has budget issue and would depend, could be a year, budget depends on current fiscal year	• Bundled payments, may be challenging for organization to allocate payments in terms of claims submission process • Better care, more convenient

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	for quality measurement, not yet defined • Enables handoff between physicians and potentially avoids readmissions, virtual presence of hospitalist not available at facility (allowable under Medicaid) • Easy way to monitor without daily visit • Some PQIs may already be managed through telehealth, more specificity, e.g. diabetes, COPD, asthma • In terms of reimbursement model, would be paid for currently , trying to explore how telehealth could be used more broadly outside of existing framework • Telehealth would also include remote monitoring and store and forward • Types of providers, modality, for payment would need to be specified • Focus on particular modalities where telehealth shown to be effective, how does hospital payment get rolled into payment models • Telehealth would need to be linked to a payment structure		

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	• Use cases 1 and 2 more focused on modalities of care, what would payors need to do to build out these services; cover as benefit, actuarial, cost of benefit, what would be reimbursement, sales, innovative products, co-payment (could be lower or higher than office), systems for claims payment based on physician contracts • Could start by defining initiatives, and then convene workgroups to develop additional details/ implementation, more granular use cases at which time a pilot could be developed • Use cases 3 and 4, unique considerations • Shared savings program has population, if improve health and efficiency, whatever they do to improve care is already built in, and that might include telehealth; although many of them don't define specific service such as telehealth or have them as a core requirement, at the same time telehealth use not prohibited; providers may not have telehealth capability,		

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	outlay of investment is needed, if organization builds in telehealth, future savings could be provided up front for investment esp in tight fiscal environment; so innovative model could include incentive for telehealth investment • Use case 3 may benefit hospitals although focused on ambulatory, hospitals could consider what investments they could make to support telehealth, how global budgets will be allocated		