State Telehealth Plan
Remote Patient Monitoring Subgroup
Electronic Meeting
August 20th, 2020
1:00p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Wooten called the meeting to order at 1:00 p.m.	
II. Process	Ms. Wooten advised participants to introduce themselves via the chat box, and reiterated the bill language. She reviewed the agenda and the leadership team.	
III. **a. Presentation from Dr. Kathy Wibberly** **b. Presentation from Dr. Bachireddy and Andrew Mitchell** **c. Workgroup Member Response**	**a.** Dr. Wibberly presented first. She presented about the effects of telehealth on chronic diseases, costs, and patient satisfaction. Some best practices improve the overall operating costs of RPM, like home installation of equipment and EMR integration. When looking at the state plan, we should look at health inequities and disparities. The state does not have ubiquitous coverage and broadband. The cost of RPM, when implementing best practices, may increase. The group should consider how to keep costs low while providing the best service. **b.** Dr. Bachireddy presented next. He discussed RPM and Store-and-Forward. DMAS has worked to transform their telehealth policy. They worked to improve a number of different elements, from eConsults, to audio-visual modalities, to payment parity and RMP for COVID-19 patients. Lessons were learned; telehealth can be rapidly scaled, and many providers are eager for telehealth authorities to be made permanent. Additionally, many patients do not always have reliable access to broadband. In order to evaluate telehealth, the subgroup should examine quality, equity, program integrity, and cost.	

	RPM has been used to enhance Prevention, Chronic Disease Management, COVID-19 Monitoring, and Lower Acuity Hospital at Home. There will be a learning curve for telehealth, but the subgroup should consider ways to "raise the bar" for the standards of telehealth. The delivery of high quality RPM requires higher costs. With this in mind, what is the incentive for providers to invest in these? **c.** Ms. Wooten asked the workgroup to respond to the following two questions: What do we need to do to be nimble enough to address our current COVID-19 public health emergency that would allow us to fully leverage all existing and potentially emerging telehealth technologies? Think about the temporary changes that might need to be made permanent and/or changes that might still be needed. Dr. Rheuban responded and said a coverage law defines RMP as the delivery of home health services. Some payers have applied that definition only to home health services, but we need to determine if it applies to other services as well. Dr. Bachireddy replied that home health is an area that there has been an uptake in telehealth. But RPM has many more use cases, around prevention and COVID-19. If RPM was only limited to home health we would be limiting ourselves. Dr. Rheuban asked the subgroup to considered modifying the definition.	
IV. Public Comment Period	Ms. Schriver commented that phone coverage to help with equity especially for patients in areas of low bandwidth as well as patients with Medicaid coverage who do not have unlimited data should be considered. Dr. Rheuban let the subgroup know that the coverage requirements in code do not apply to Medicaid. She asked Dr. Bachireddy about the implications of this.	

	Dr. Bachireddy answered that for new services to be covered in Medicaid, the General Assembly has to give it authority to do that. They will also have to give a budget for any given service. Dr. Rheuban asked if it might be at parity, and Dr. Bachireddy let her know that it may be reimbursed on the same basis to his knowledge. However, there are lawyers and lawmakers that still need to decide this. Some folks at DMAS define telehealth as interactive audio visual. This is another example of differing definitions, but there is value in keeping those definitions different, but the subgroup should consider if there is a difference in value. From a clinical perspective, audio-only seems to be lesser in value and leaves the clinician wanting more. Dr. Rheuban followed up by saying that the statute states a doctor-patient relationship cannot be established over the phone. Ms. Pier-Ferguson asked the subgroup to ensure that the devices the patient would be using would be auto renewed and recounted a time when a provider attempted to reach the patient but the phone was disconnected.	
V. Adjourn	Ms. Wooten reviewed next steps and adjourned the meeting at 1:58 p.m.	

State Telehealth Plan
Criteria for Use Subgroup
Electronic Meeting
August 20th, 2020
2:15 p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Ms. Wooten called the meeting to order at 2:15 p.m.	
II. Process	Ms. Wooten introduced the subgroups and leaders and Mr. Perkins reiterated the bill language.	
III. **a. Presentation from Dr. Kathy Wibberly** **b. Presentation from Dr. Andrew Ramsey** **c. Workgroup Member Response**	**a.** Dr. Kathy Wibberly gave a presentation on Criteria for Use for Telemedicine. The Standard of Care should not change from in person; it should be the same as it would be under in-person circumstances. It is important to consider the existing infrastructure to support telehealth technologies. The clinician has to overcome the obstacle of teaching the patient. We must evaluate if telehealth will actually work; if the clinician knows how to use it; and if the correct tool for the condition. Likewise, is it the same standard or better than in-person care? Is it the same or better than no care? The subgroup must also consider how we measure harm. **b.** Dr. Andrew Ramsey gave a high level overview of telehealth as it relates to Emergency Medical Services. There have been changes in defining the "originating site" and on-scene care via telehealth is now possible. This will also limit the number of low acuity calls, as well as leave ambulances and other emergency vehicles available. However, on-scene telehealth does not directly reimburse EMS agencies yet, and there is inconsistency across payers. Those telehealth calls that are reimbursed, are done so	

	at a lower rate than appropriate. The applicability of EMTALA (requirement of medical screening exam for emergency conditions & stabilization) must be considered. There may be system-level benefits if telehealth is implemented properly. **c.** Mr. Perkins presented the following question to the subgroup: "What do we need to do to be nimble enough to address our current COVID-19 public health emergency that would allow use to fully leverage all existing and potentially emerging telehealth technologies?" He asked the group to consider the temporary changes that might need to be made permanent and/or changes that might still be needed and/or what processes need to be put into place to address how decisions are made regarding what changes are temporary/for emergencies only and what changes should be made permanent? Ms. Evanko commented that there may be issue addressing the different types of providers. One size won't fit all for telehealth. Different professions may need different guidelines. Mr. Perkins expressed the finished plan would ideally address the different disciplines as well as prehospital, in hospital, home health, alternate sites, etc. The group can work on these as time progresses Dr. Yee asked if the state/federal government already had guidelines for telehealth. Mr. Perkins asked that if anyone in the subgroup had information regarding this, to please forward it to us. Dr. Ramsey added that the Board of Medicine might be the ones to speak with in order to determine restrictions.	

	Dr. Adekoya mentioned indicated that out of state providers can provide services, but need a Virginia license. Mr. Gray commented that in the executive order, there was flexibility (including out-of-state) for behavioral health due to the pandemic. Much of these are being provided in a telephone-only context. Dr. Yee said that the biggest challenge may be to craft the document to what we think the medicine will evolve into in the future. This document will outlive COVID-19; what will telemedicine be in 5-10 years?	
IV. Public Comment Period	There was no public comment.	
V. Adjourn	Mr. Perkins discussed next steps and adjourned the meeting at 3:02 p.m.	

State Telehealth Plan
Sustainability Subgroup
Electronic Meeting
August 20th, 2020
3:30p.m.

Topic/Subject	Discussion	Recommendation
I. Welcome	Mr. Perkins called the meeting to order at 3:30 p.m.	
II. Process	Mr. Perkins introduced the subgroups and leaders. He explained the Sustainability bill language and asked the subgroup to respond to two questions: What would an innovative payment model look like? Does it need a sliding cost scale?	
III. Workgroup Member Comments	Ms. Schriver told the subgroup that an innovative payment model idea could be a value based care model. Payers can see the results and the improvement of outcomes, increase access for patients in urban and rural areas. The concept of patient care could be integrated with value-based care. Dr. Rheuban commented that value-based care delivery models would work in this scenario. What is the payment model that works? Dr. Yee indicated that value-based care model can be murky. Population becomes another issue – counties get x-amount of dollars per person so some models might be difficult to execute. Mr. Berg agreed with the value-based care model comments of the subgroup. He asked if the sliding scale referred to the patient's ability to pay, or the services rendered.	

	Mr. Perkins clarified that it referred to a range of different services being provided. How should the payment model look? Mr. Berg indicated that he agreed, there are many different variables, and that the subgroup's scope should be on a larger scale instead of the minutia. Mr. Perkins told the group that the goal is to take the input they provide and use it to frame out what the plan should look like. Ms. Schriver asked the workgroup again about value-based care. Would this type of model differ across the different uses of telehealth? Mr. Perkins clarified that this is a plan that will be used as a recommendation for the Board of Health and the General Assembly. Dr. Yee advised the subgroup not to forget about the intermediary services like EMS who won't directly provide telehealth, but will use these services to help the patients. How do we pay EMS for this? RPM should be a bill for service. It is different from a telephone call from the doctor; telemedicine is audio-visual. Mr. Perkins told the group there is a workgroup working to ensure broadband is available for everyone in the commonwealth. That being said, it will be a while till that access is available for each citizen. Ms. Schriver said we have not launched the emergency triage transport program in Roanoke yet. But a payer has decided for Medicare patients, they may try to reduce the cost for payers. We are looking at the Treat-in-Place option. There will be a payment offered for the EMS service and for the EMT, based on certain criteria for Treat-in-Place. This is a five year program. Dr. Martin introduced himself as a Pediatric Clinician. He said we are doing a lot more mental health work, and this is an access point for him and others to received payment. He and his colleagues have discovered that telehealth has given them	

	increased access to many of their patients, especially those with mental health issues and/or disabilities. We need to keep this in mind because clinicians are not willing to do telehealth and only be paid half of what they were originally making. Mr. Berg asked if the EMS reimbursement would be a percent or flat rate. Dr. Yee clarified that it is the rate they usually use minus the mileage. Dr. Elward indicated that value-based model is that it could inadvertently put the burden on providers. We should not create an overly complicated system that will prevent providers from providing the care that's needed. Mr. Berg indicated that reimbursement may not cover all the costs. The sustainability may be in jeopardy. Ms. Schriver said that in an integrated delivery and financial system, they had to make formal presentations to make sure the payer funded the digital technologies they put in place. There is a possibility of working with payers. Mr. Gray commented that there are multiple innovations and models in the private sector as well. Dispatch Health in Richmond is one example – "bring the ER to your home". Plans are contracting with that model. The models aren't all built around the existing set of structures.	
IV. Public Comment Period	There was no public comment.	
V. Adjourn	Ms. Wooten adjourned the meeting at 4:02 p.m.	