

Meeting Minutes

June 27, 2018

1:00pm-3:00pm

7001 220th St SW, Mountlake Terrace, 98043. Bldg 2.

Attendees (In Person): John Scott (UW), Representative Joe Schmick, Chad Gablein (Virginia Mason), Cara Towle (UW), Brodie Dychinco (Cambia Health Solutions/Regence), Sheryl Huchala (Premera Blue Cross), Sarah Orth (Seattle Children's), Chris Cable (Kaiser)

Attendees (By Phone): Sheila Green-Shook (WA State Health Information Management Association), Stephanie Cowan (MultiCare), Lori Wakashige (Legacy Health), Rep Marcus Riccelli, John Boze (WA Labor and Industries), Denny Lordan (Providence), Kathleen Daman (Swedish), Ricardo Jimenez (Sea Mar)

Members of public: Ian Goodhew (UW), Thea Mounts (OFM), Sharon Lindsey (Seattle Children's), Mellanie McCaleenan (WA State Dental Association), Sarah Kwiatkowski (CHPW), Leslie Emerick (Home Care Association WA), Shawn Akavan (Amerigroup).

Meeting was convened at 1:05pm

Welcome Rep Riccelli! The Representative has been part of the Healthcare Committee and is the House Democratic Majority Whip. He has worked on multiple telehealth related bills including the medical licensure compact.

- I. **Review of 05.07.18 Meeting Minutes**
 - a. Minutes reviewed
 - b. Rep Schmick motioned for approval, Chad Gablein seconded approval
 - c. Motion passed unanimously to approve meeting minutes
 - d. **ACTION:** May meeting minutes to be posted on Telehealth Collaborative Website
- II. **Resources available from OCHIN – John Scott**
 - a. Northwest Regional Telehealth Resource Center (NRTRC) provides services and supports to anyone in the Northwest region

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- b. OCHIN is a health IT consulting non-profit based in Portland, and is an additional resource
 - c. OCHIN operates the CA Telehealth Network (CTN), funded by HRSA. They serve over 10,000 physicians with an expertise in technology solutions such as PTSO (the EMR that multiple community health organizations use in WA State).
 - d. Have helped small organizations get over \$5 million in FCC grants
 - e. Help negotiate rates for hardware and other purchases
 - f. Focus on safety net organizations
 - g. Denny Lordan has had experience working with OCHIN in CA and endorses them as a good organization.
 - h. **ACTION:** Post link to OCHIN on Telehealth Collaborative website
- III. Telemedicine Parity, Roadmap – Sen. Becker**
- a. Sen Becker was unable to attend the meeting
 - b. **ACTION:** Forward presentation to the next Telehealth Collaborative meeting
- IV. Telemedicine Parity, Current vs. Future State – John Scott**
- a. Current state: if patient is seen in person there is a clinician charge (aka “professional fee”) and a facility fee. The facility fee is incurred if the clinic is attached to a hospital. Example: commercial level 4 professional fee could range from about \$150-\$250. The facility fee can sometimes be almost the same amount. Medicare pays \$131.70 for CPT 99204.
 - b. Proposed future state: Follow the Medicare model in which the professional fee would remain the same as an in-person visit and the “originating site” receives a version of the facility fee, which is lower and coded as Q3014.
 - c. Molina already follows the Medicare model
 - d. The legislation does not make clear that parity relates only to the pro fee.
 - e. Ian Goodhew: at the time the bill was passed, verbiage “parity” was used frequently, but discussion did not reach this level of specificity regarding the pro fee/facility fee.
 - f. Clarification: Q3014 can be billed from any clinical originating site, not just those associated with a hospital. Need clarification on whether these codes come in on the professional bill for clinics that are freestanding (not hospital associated). A billing expert from Premera believes that it would come in under a professional claim. For a hospital based clinic, the fee would come in on a UB.

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- g. Clarification: proposal is to use Medicare methodology, not Medicare rates
 - h. Sarah Orth: concern that Medicare methodology does not cover direct to consumer, home originating site, or remote monitoring. Staff are helping to virtually “room the patient” and a \$25 originating site facility fee would not cover those costs.
- V. Telemedicine Parity, CPT codes –Brodie, Sheryl, Shawn, Chris, Frances**
- a. Brodie noted that this presentation does not contain formal positions, but rather considerations for a parity payment pilot
 - b. Defining “Parity”: plans would like to see a clear statement as to what Parity means to the Telehealth Collaborative.
 - i. Practice expense: Medicare pays a different RVU when service is billed with place of service 02 versus the clinician’s office
 - ii. How much a service is reimbursed is based on the RVU weight and the conversion factor. The Relative Value Unit (RVU) is made up of 3 components: (1) work component, (2) malpractice component, and (3) practice expense. The first two are the same for telehealth, but there may be a different in the practice expense. Although conversion factor is the same in Medicare for telehealth, the RVU weight is actually different.
 - iii. Collaborative members need to decide if Parity would mean the same conversion factor, or same overall dollar value (which would require the RVUs to be the same as well). Bottom line: even if the physician bills the same code, if practice expenses are lower based on place of service (POS) the RVU calculation would be lower. This would still align with Medicare methodology.
 - iv. Providers noted that practice expenses are not necessarily lower because telehealth equipment, peripherals, technologists represent new costs. These infrastructure costs are significant.
 - v. Chad Gablein: when providing remote primary care visits, Virginia Mason is finding the costs may be even higher for telemedicine than in-person. The purpose is to improve access and bring care to underserved areas versus lowering costs from their perspective.
 - vi. Sarah Orth: Seattle Children’s needs space for providers to sit and complete telehealth visits. That clinical space is then not available for in-person visits.

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- vii. Tele-presenters are another expense at the originating site. They are often nurses trained on some palpations and other exam aspects. Their exam is guided by the physician.
 - viii. Chris Cable: there is some clinical drop-off from the exam over telehealth in that the clinician is not able to physically touch the patient.
 - ix. Dr. Jimenez: proposed consideration that parity may not be the best approach to comparing telehealth and in-person services
 - x. RVU is not controlled by the health plan, and serves as the basis for most services. Could consider focusing on the “negotiated rates”. Rates include the conversion factor which is controlled by the plans. Brodie noted that the rate and itself and the negotiated rates would result in similar conversations.
 - xi. Chris Cable: consider term payment “equity” which takes into account the costs to the provider for the service and the value to the patient, which are at different levels for the in-person vs. telehealth service. KP expects that dermatologists doing telehealth will see about 1/3 more patients via telehealth and are valued at the same rate—their providers are satisfied to do this. Found for eConsults that 25% actually replaced a new visit, so value eConsults at a quarter of the in-person visit.
 - xii. Possibly too early to discuss specific CPT codes, as need to first decide what definition of parity will be and which services will be included.
- c. How does consumer adoption factor in? There are providers who purposefully price lower to make the service more appealing to patients.
- d. How does provider adoption factor in? If payments were on par, would this motivate more clinicians to provider telehealth services?
- i. Chris Cable: telehealth has so many different models, it makes it difficult to define one payment strategy; not sure that Medicare model will truly meet the need. What health system wants to accomplish and what patient’s might want to accomplish may be different.
 - ii. Emily Yu: Multicare has two pilots in their primary care clinics, which aim to have providers build video visits into the course of their normal clinical day. Providers are concerned that their clinic

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will take a financial loss for replacing in-person visits with video. This has been a significant barrier.

- iii. Dr. Jimenez: their organization is using telehealth to supplement current in-person work vs. replace it. Their clinicians are excited but their organization is concerned about being able to provide the resources to make the service sustainable.
 - e. Rep Schmick posed the question, what are our goals with a parity pilot? John Scott: UW Medicine sees telehealth as a tool to drive toward the triple aim. For many patients, the alternative to telehealth care is no care at all. Sarah Orth: goal is provide the right level care at the right time in the right way. Looking to remove the barriers of infrastructure, internet bandwidth etc.
 - f. Employers are looking to telehealth to improve worker productivity—a video visit means workers don’t need to go offsite for a visit.
 - g. Ian Goodhew validated that this discussion is aligned with the legislative assignment to review “Payment Parity”. Level of detail in defining recommendations is appropriate.
 - h. What is the role of the clinic administrator in telehealth? There may be a component of clinic administration that is part of parity solution.
 - i. What do plans feel will be impacted?
 - i. This item was not addressed by the Collaborative due to meeting time constraints
 - j. What needs to come from a parity pilot and what will be done with the findings? What if the findings are inconclusive?
 - i. This item was not addressed by the Collaborative due to meeting time constraints
 - k. **ACTION:** Brodie to share examples of RVUs for in person vs. telehealth services
 - l. **ACTION:** Telehealth Collaborative to develop a list of items to define related to payment parity and discuss at the next meeting.
- VI. Telemedicine Parity, All Claims Database – Thea Mounts, OFM**
- a. The All Claims Database was created by legislation passed in 2014 and was amended in 2015, with significant work by Sen Becker to improve the statute. This allowed the data from the commercial carriers to be brought into the database.
 - b. Purpose of the database: assist patients to make better choices, promote cost and quality in the state

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- c. Finding came from two CMS grants and the SIM grant. The APCD is required to be self-sustaining in the long-term through sale of data.
 - d. Oregon Health Sciences (OHSU) is contracted as the lead organization. OHSU is subcontracted with Onpoint Health Data, which has supported ~50% of APCDs nationally.
 - e. Data sources: HCA, health and dental, prescription drug claims, labor and industries. Self-funded plans have option to submit but are not required. Data is submitted quarterly.
 - f. Working to expand the legislation to include data for all WA residents, not just those who have health plan policies based in WA State.
 - g. Results of historical data submission: includes 4 million covered lives in WA
 - h. Utilizing Unique IDs to try and link patient data across time, even when there is a transition between different types of plans.
 - i. Different levels of data elements will be available to different types of data requestors, such as researchers, government agencies, lead organizations etc.
 - j. Includes a master provider index (MPI) to track where providers are practicing and what types of patients they are seeing
 - k. Use case example: Department of Health interested in looking at utilization of LARC devices.
 - l. Telehealth Collaborative would probably be an agency type E and would need to go through the request process. Legislation would be needed to give the Collaborative access without going through the request process.
 - m. Analytics could be done through OHSU or Onpoint Health Data but would require funding. Data extracts would need to be paid for as well.
 - n. Products include: data file extracts, cloud-based analytic enclave, standard reports and ad hoc analytic reports
 - o. Data extracts will include the minimum variables required to complete the work.
 - p. WA Healthcare Compare website will be published on 6/29/18
 - q. Denny Lordan: could Collaborative pull data regarding payer compliance with parity law? Could look at QT modifier denial rates.
 - r. Policy bill references accessing the APCD but the Collaborative is not funded to the level required to pay the price of the products.
- VII. Proposed Training Certificate Requirement (time permitting) – Denny Lordan**

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- a. **ACTION:** Forward this topic to the next Telehealth Collaborative meeting
- VIII. Public Comment Period**
 - a. **Shawn Akavan (Amerigroup):** discussions about parity are going to get harder as more equipment, such as remote monitoring, come into play. Amerigroup wants to encourage providers to use telehealth and are interested in removing barriers. Recommend to put the ball in the court of providers to understand how they need to be reimbursed to increase adoption. Amerigroup has not seen the adoption of telehealth that they want, and feel the providers need to lead the conversation.

Next Meeting: Aug 30 1-3pm at Gonzaga University.

Meeting adjourned 2:54pm