ALASKA MEDICAID REDESIGN IMPLEMENTATION

TELEHEALTH WORKGROUP | NOVEMBER 2, 2016

MEETING ATTENDEES

Workgroup Members:

Christiann Stapf	Division of Health Care Services, AK Department of Health and Social Services (DHSS) – Project Lead
Brent Fisher	Alaska Sleep Clinic
Brooke Allen	Independent Practitioner: Behavior Analyst
Christopher Simon	Tanana Chiefs Conference
Connie Beemer	Alaska State Hospital & Nursing Home Association (ASHNHA); Alaska Collaborative for Telehealth and Telemedicine (ACTT)
Denise L. Daniello	Alaska Commission on Aging
Georgiana Page	Alaska eHealth Network
Laura Johnston	Southcentral Foundation
Mark T Erickson	Alaska Psychiatric Institute/ Div. of Behavioral Health, DHSS
Mark Williams	Providence
Matthew Hirschfeld	Alaska Native Medical Center
Monique Marquis	Fairbanks Memorial Hospital
Philip Hofstetter	Norton Sound Health Corporation
Richard Kiefer-O'Donnell	University of Alaska Center for Human Development
Robert Onders, MD	Alaska Native Tribal Health Consortium
Stuart Ferguson	Director of Telehealth, Alaska Native Tribal Health Consortium
Thad Woodard, MD.	Private Practice Pediatrician (Alaska Center for Pediatrics)
Trina McCandless	EMT/Firefighter - North Slope medic; POW & S.E. Experience

Other Attendees:

Heather	
Jan Walsh	Providence
Jennifer Harrison	Executive Director, Eastern Aleutians Tribe
Jessica Cher	
Karl Garber	Executive Director, Alzheimer's Resource of Alaska
Melissa (online participant, no last name provided)	
Melody	Eastern Aleutians Tribe
Michael Baldwin	Alaska Mental Health Trust Authority

DHSS Staff:

Beth A. Davidson	Commissioner's Office
Deborah L Erickson	Commissioner's Office
Christine S Goetz	Office of Rate Review
James B Gallanos	Prevention Section
Katherine A. Tompkins	Office of Rate Review

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Kelda O. Barstad	Senior and Disability Services Management
Lisa L. Rosay	Treatment/Recovery, Div. of Behavioral Health, DHSS
Margaret Brodie	Div. of Health Care Services, DHSS
Renee A, Gayhart	Commissioner's Office, DHSS
Donna M. Steward	Commissioner's Office, DHSS
Shannon L. Cross-Azbill	Div. of Juvenile Justice, DHSS
Susan M Mason-Bouterse	Div. of Public Health, DHSS
Thor M Ryan	Information Technology Services, DHSS
Tarik Thomas	DHSS - Senior and Disability Services

Support Staff:

Shanna Zuspan, Agnew::Beck
Molly Mylius, Agnew::Beck

MEETING OBJECTIVES

1. Review current legislation and policy.
2. Review and discuss work plan vision, goals and objectives.
3. Discuss and outline group charter.
4. Review existing policy and regulations and discuss gaps and needed changes.

SUMMARY OF DISCUSSION

ITEM	DISCUSSION
Welcome and Introductions	• This workgroup is an advisory to the Department and will help identify telehealth expansion opportunities, barriers and recommended next steps. • This is the first of four workgroup meetings.
Review and Discuss Senate Bill 74 + Current Medicaid Policy	Introduction to Senate Bill 74 (SB74). For more details, see the presentation. • SB74 defines telehealth as the following: *The practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of health care data through audio, visual, or data communications, performed over two or more locations between providers who are physically separated from the recipient or from each other or between a provider and a recipient who are physically separated from each other.* • SB74 expands on the types of licensures that permit telehealth and applies to a variety of clinicians (see presentation for the full list). • SB74 Requires that the department implement a program for reforming the Alaska Medical Assistance program and stipulates that the reform must include expanding the use of telehealth for primary care, behavioral health and urgent care. • SB74 also requires DHSS to o Identify areas of the state where improvements in access to telehealth would be most effective in reducing the costs of medical assistance and improving access to health care services for medical assistance recipients.

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	○ Make efforts to improve access to telehealth for recipients in those locations. ○ Report to the Legislature about the legal and technological barriers to the expanded use of telehealth, improvements in the use of telehealth in the state, and recommendations for changes or investments that would allow for the cost-effective expansion of telehealth. Introduction to Medicaid Policy. For more details on Medicaid policies related to telehealth delivery, covered telehealth services, billing, conditions for payment and telehealth uses for behavioral health, see presentation slides. • Alaska Medicaid will pay for a covered medical service furnished through telemedicine application if the service is: ○ Covered under traditional, non-telemedicine methods ○ Provided by a treating, consulting, presenting, or referring provider ○ Appropriate for provision via telemedicine • Clarifying Questions from Workgroup Members: ○ "Appropriate for provision via telemedicine" – who decides whether the service is appropriate? Is this based on physician discretion, patient discretion, medical board? Does this need to be addressed through policy? ○ How does the location of service impact telehealth eligibility? Medicaid says a provider shortfall needs to exist, but SB74 suggests that isn't true in Alaska. The Centers for Medicare and Medicaid Services (CMS) largely leaves it up to states to decide for Medicaid. Medicare standards are much more restrictive. ○ During the last legislative session, there was a discussion about whether Teladoc services would be covered. Would Medicaid cover those services? ▪ Answer: If they are a contracted provider in the State of Alaska and are providing services that meet Medicaid policy standards, yes. ▪ Teladoc is already available in Alaska; they are partnering with self-pay employers. They have physicians registered in Alaska but not physically located in Alaska. ○ "Pharmacological management services" is listed under covered services, but "pharmacy" is listed under exclusions. What is the difference? ▪ In this case, "pharmacy" refers to the dispensing of medications. Medicaid does cover prescription medications. ▪ Need to differentiate between clinical pharmacist interventions and pharmacists who dispense. ○ Does Medicaid cover mail-order pharmacy? ▪ Yes. ○ In Haines, providers at the SEARHC clinic have reported that telehealth counseling services have increased patient use of counseling since patients can speak to someone outside of their community (their concern is for privacy issues). Would this service be available to patients in a small town where a counselor was available? ▪ If the patient is a Medicaid recipient, no, since there are

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	geographic restrictions. ▪ According to state medical board policy, telehealth is sanctioned in locations where there is no practitioner available to conduct a **physical** exam. However, this does not apply to mental health practitioners. ▪ State Medical Board Policies, Medicaid Policies and SB74 have inconsistent/conflicting guidance, so the Board will have to update their policies. • Can you share more details about the registry requirement in SB74? o The Department of Commerce, Community and Economic Development (DCCED) is developing a telehealth registry, so that responsibility is not under the scope of this workgroup. However, there is overlap so there will need to be some collaboration. o Can the registry also be used as an education and awareness tool for helping providers and patients connect with telehealth providers? • Is remote patient monitoring something we could include in the telehealth discussions we are having? Does that fall within this workgroup? o Yes, especially if there are policy issues, potential cost savings (especially for Medicaid recipients) and other relevant implications. However, the workgroup would probably not provide recommendations on detailed topics such as technology and infrastructure needs for remote patient monitoring.
Review and Discuss Work Plan, Define Group Charter	• The Telehealth Workgroup will need to be strategic about what we can accomplish and how we can best utilize this group of stakeholders over the four meetings we have together. • The work plan outlines the scope and direction for this work group over the coming months. It seeks to address the following objectives from SB74: o expansion of the use of telehealth for primary care, behavioral health and urgent care; o identification of areas of the state where improvements in access to telehealth would be most effective in reducing costs of medical assistance and improving access to health care services for medical assistance recipients; o recommended steps to be taken by the Department to improve access to telehealth in those regions; o completion of a report to the legislature that addresses identified legal and technological barriers to the expanded use of telehealth, improvements in the use of telehealth in the state, and recommendations for changes or investments that would allow cost-effective expansion of telehealth. • Does the description capture the core mission of the group? Are the goals in line with the purpose of the group? o The workgroup agreed with Dr. Onder's suggestion of framing everything in the following categories:

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	▪ Patient Experience (includes quality, access) ▪ Improving Population Health ▪ Provider Experience ▪ Reducing Per Capita Costs. ▪ *Note: some action steps may fall under multiple categories* • Questions and comments from workgroup members o Is this group focused on telehealth exclusively through Medicaid? ▪ This process needs to consider payers other than Medicaid. Medicaid is not the driving force of health care costs, and so it will be important to engage other payers, including both those who do and do not cover telehealth. SB74 focuses heavily on Medicaid, but this workgroup can make recommendations that are more broad. o Should we be establishing targets? ▪ There is a dedicated Quality and Cost Effectiveness workgroup responsible for setting targets. There will likely be some overlap between this telehealth workgroup and that effort so it will be important to collaborate. o Is the biggest objective of this group to reduce costs? ▪ The workgroup is not responsible for specific cost targets, but should identify broad approaches that could drive down costs and identification of legal and technological barriers with recommendations for overcoming those barriers. ▪ Telehealth costs may go up, because other in-person visits and overall system costs are going down. ▪ In general, avoid use of the term "cost containment" in the context of this project – it has negative connotations for many providers. • What is the timing of the workgroup recommendations? Should we prepare anything that needs to be ready by the start of the legislative session? o No – there is not time for an interim report, especially with the required research and public review comment period. However, recommendations need to be complete by the end of the fiscal year. • If there is an advocacy strategy that falls outside the purview of this workgroup, the Alaska Collaborative for Telemedicine and Telehealth (ACTT) may be able to act as an interim advocate/voice to the legislature if we identify critical needs/recommended modifications to statutory changes.
Review and Expand on the Work Plan Action Steps	• The group reviewed and discussed the proposed action steps. Key discussion highlights are included below. • **General Comments** o There are two different ways telehealth can increase access and reduce costs: ▪ Saving time and money on clinic visits by increasing connectivity between providers and patients who are local. The current

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	challenge here is **reimbursement**, as these types of interactions are generally not billable. ▪ Savings on travel and lodging costs for patients in remote communities who otherwise have to travel for services. These telehealth services are generally already billable; the challenge is **technological infrastructure and connectivity**. ▪ Identify ways to incentivize payment and billing for telehealth, including improving connectivity and infrastructure (to increase access in rural communities and reduce travel costs) and expanding billable options to reduce unnecessary office visits. o Look at other states, countries to learn more about what's working related to remote patient monitoring, peer-reviewed literature and other innovations. ▪ Evaluate other state and international models and identify tools and methods that could be adapted for Alaska telehealth. • **Covered Services and Reimbursement** o Consider how to use telehealth to reduce costs and increase access for people with disabilities. For example, many kids with autism are in locations without access to services – there is no follow-up from screening to diagnosis. We could use telehealth to decrease the time it takes to get behavioral health services, which would reduce disparities. There would be significant long-term cost savings. ▪ Identify underserved populations and ways in which telehealth could improve access, and decrease time to receive diagnosis and service provision. ▪ Kelda: the waiver research efforts are looking at this topic as well. These two groups should be talking to one another to make sure the recommendations are in alignment. Kelda can present at the next workgroup meeting to help identify overlap and gaps. ▪ The work group could identify criteria or a process for identifying priority regions. o What incentives can the state offer? For example, can providers receive continuing education (CE) credits for training on legal and ethical issues related to telehealth? o Dr. Thad Woodard: "As a pediatrician, most of what I do does not qualify." Primary care physicians have many daily interactions every day that reduce costs and improve access, but which are not covered. Many issues can be handled over the phone but physicians don't get paid unless the patient comes into the office and can bill for the interaction. The current reimbursement system fails to incentivize primary care. This is also true for mental health care physicians who provide services over the phone. o Consider revising medical record requirements to require a physical exam for controlled substance prescriptions. • **Costs** o The current focus on reduction of costs is at a point-in-time transactional level, whereas it should be at a longer-term, population level. There will be

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	short term increases as systems are designed and put into place. o Reducing costs for whom? The patients? Payers? Communities? State? o How do we identify what the biggest costs are in the short term? Need to know more about current expenditures before thinking about savings. Will we have access to data related to current travel costs, clinic visits, etc.? ▪ An actuarial Medicaid data book will be available in February or March of 2017. If the telehealth workgroup has specific data requests, put in a request, although it may take a while to get the results. The state's consultant, Milliman, is reviewing five years of Medicaid data. o There are technological costs to install, upgrade and maintain the technological systems that support telehealth. Medicaid rates offset the provider's time (the marginal cost of the service), but are insufficient to cover the full costs of the technology itself – they take advantage of the commercial insurance world and assume that infrastructure costs are paid for by someone else. o There may be some populations that are not accessing care at all and who will start using telehealth services, thereby increasing costs in some areas due to increased access. o Need to examine costs in order to make recommendations. What is the baseline and how are we shifting? How will we access and use the data? Where are costs going? o This effort should also be aligned with and informed by statewide priorities via the Healthy Alaska Plan. o Identify metrics to evaluate change and cost containment. • **System Capacity and Tools** o Capacity: We should also consider capacity for expanding telehealth. Are there enough providers, what are the type of providers who could provide this service? Who is going to use those services? Do existing programs have capacity to support more volume? ▪ This includes both interstate and intrastate capacity. Alaska is leading the field in many ways. ▪ There are already contracts for telehealth with out-of-state providers, especially within the tribal health system. SB74 eliminated the need to be physically present in Alaska to provide telehealth services; physicians just need to be registered and licensed here. o Electronic Health Records should be included in the discussion. • **Policies and Regulation** o Need to find compatible telehealth solutions that are HIPPA compliant. o Are there geographic limitations on acceptable locations? For example, can video be used to make evaluations in the home? o SB 74 has telehealth sections that are poorly written and redundant, including recommending policies that don't make sense or that could actually limit access to telehealth. Can this group re-write that text? ▪ Shouldn't propose full re-writes but if the language in the bill is a barrier, then this group should identify areas that need clarity or

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	modification. ▪ The different governing bodies and sets of policies need to be in alignment. Through this process, we can begin to identify some of the inconsistencies and put forward recommendations to help resolve them. • Collaborations and Partnerships o This group should engage with relevant state licensure boards. They will have concerns related to quality and achieving the appropriate level of services. o Collaborate with stakeholders to identify barriers to the use of telehealth and to review and confirm recommendations. • Additional comments o Address technology and programs separately. This will make it more achievable. ▪ Research, identify and evaluate platforms. ▪ Evaluate the current capacity and opportunities to expand capacity through telehealth. o Evaluate and make recommendations on new and innovative ways to use telehealth. ▪ Mississippi does home disease management and intervention. ▪ What are other arctic countries doing who have similar environments? Canada, Russia, Sweden. ▪ We should look at increasing the capacity of presenter providers, too. AMHTA is looking into this right now. Project Echo is a national model that provides case-based learning with an export hub and spokes. How can we train people and increase adoption?
Review Other Components of the Work Plan	• Workgroup members agreed that the following draft tables/outlines in the Work Plan look good and do not need any edits: o Legal Authorities and Medicaid Manual Change Requirements o Administrative and IT Requirements o Resources Allocated o Training Required • Stakeholder Engagement: workgroup members recommend adding the following to the list: o Licensure boards, including the Medical Board, Mental Health Clinicians, Community Health Aid Board, National Association of Social Workers, Board of Nursing, Board of Pharmacy. o Alaska Council on Emergency Medical Services (EMS) o Provider Associations • Success Metrics: add “positive feedback and acceptance of the state’s report by the Alaska Legislature”
Identify Next Steps	• 12:08- 12:13 pm, question/recommendation. Stewart: present? Yes, at next mtg. Who should present? • Feedback from Medical Boards o This workgroup should conduct outreach to different boards to solicit their

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	feedback and make sure they are aware of what's going on. Share the work plan and draft recommendations with them. o Christiann will share the list of boards with the workgroup to identify which ones should be included, how to engage them and what questions to ask. • Is there a list of legal authorities regarding telehealth? o Yes, Christiann will send out what she has compiled. If anyone has suggestions for additions, please let her know. • What data does this workgroup need? Does Medicaid already have data on the costs to deliver different services by different geographies and populations? o The Quality and Cost Effectiveness Work Group (chaired by Donna Steward) is also looking at this topic – it will be a big challenge. ▪ Christiann will meet with Donna to learn what is available through reporting tools. Margaret and/or Jason Ball are also helpful data contacts. ▪ Christiann will share what she finds, and workgroup members are encourage to specify what data would be most helpful, including which data points and what slicing/sorting options are desired. ▪ Collecting data is time and resource intensive, so when possible, try to use what's already available/analyzed. Can we join other data requests instead of duplicating or putting in our own? Christiann will submit our initial data needs list to other section heads to see if anything on the list overlaps with what is already available or in progress. ▪ Many other systems have their own non-Medicaid data, including senior and disability services, public health and behavioral health. This is often more clinical and less claims-related, but could still be helpful.
Discuss Timeline and Next Meeting	• Outline for the next meeting: o May need a longer period: six to eight hours. o Discuss the following topics: ▪ What are the legal and regulatory barriers to implementing telehealth in Alaska? ▪ Technology and programs: what is available today? What are the barriers and opportunities? ▪ Review/share back on data: what's available? o Other presentations and guests: ▪ Chris Simon can arrange for someone from TCC's health department to present. TCC has been doing a lot of telehealth in their villages. ▪ Kelda Barstad can present at the next workgroup meeting to help identify overlap and gaps with the waiver recommendations group. • Recommendations for improving subsequent meetings: o Set up videoconferencing for those participating remotely (in Juneau).

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	Need to reserve TVC rooms in both locations. o Build in time for public comments, so public attendees can provide feedback. o Send presentations and documents ahead of time. o Improve the audio for those participating remotely, including encouraging people to relocate closer to the microphone when speaking.

NEXT STEPS + ACTION ITEMS:

- Christiann to send out the following materials to the workgroup:
  - Revised Telehealth Workgroup Work Plan.
  - Medicaid Policy Provider Manual.
  - Telehealth "policy packet," including a list of legal authorities on telehealth.
  - Send out a list of attendees, with affiliations listed (included in the notes above).
  - Presentation slides and notes from today's meeting.
- Follow-up prior to the next meeting:
  - Christiann will share the list of boards with the workgroup to identify which ones should be included, how to engage them and what questions to ask.
  - Data Requests:
    - Christiann will meet with Donna to learn what is available through reporting tools. Margaret and/or Jason Ball are also helpful data contacts.
    - Christiann will share what she finds; workgroup members are encourage to specify what data would be most helpful, including the types of desired slicing/sorting options.
    - Christiann will submit our initial data needs list to other section heads to see if anything on the list overlaps with what is already available or in progress.
  - Identify and invite presenters and other participants to the next meeting.

There are three more Telehealth Work Group meetings, scheduled for January, March and May 2017.