Telemedicine Task Force
Finance and Business Model Advisory Group

April 29, 2014 Meeting Summary

Key discussion items:

- The Maryland Health Care Commission (MHCC) provided an overview on the role of the Telemedicine Task Force Advisory Groups in developing recommendations for telehealth diffusion in Maryland; the recommendations will be included in a legislative report due to the Governor, Senate Finance Committee, and House Health and Government Operations Committee on December 1, 2014, as required by Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*
- The Finance and Business Model Advisory Group reviewed a revised draft definition for telehealth that will be proposed in the legislative report
    - The revised draft definition was developed based on discussions during the initial 2014 Telemedicine Task Force meeting and subsequent advisory group meetings
    - The revised draft definition is intended to broaden the scope of telehealth to include a wide range of telehealth technologies and applications and a variety of health care professionals
    - Telemedicine is currently defined in law as: *the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient*[1]
    - The revised draft definition for telehealth is: *the delivery of health education and services using telecommunications and related technologies in coordination with a health care professional*
    - Finance and Business Model Advisory Group members (members) discussed how the revised draft definition would be applied and the financial impact, especially in terms of reimbursement
- The MHCC presented innovative telehealth use cases developed by the Clinical Advisory Group that could be incorporated in new models of care delivery (the table of use cases is available here)
- Members reviewed use case #1, *improve transitions of care between acute and post acute settings through telehealth*, which aims to reduce unnecessary hospital admissions
- Members identified the following financial and business model challenges when considering incorporating the use of telehealth into non-fee-for-service payment structures:
    - There is uncertainty of payment structure and impacts of health care reform, including the hospital waiver
        - Incentivizing hospitals to share their savings, especially when the savings may not be realized may be difficult
        - There is a need to explore how shared savings would best be allocated

[1] Md. Code Ann., Health - General § 19–319

        - Most physicians still practice within the fee-for-service model, and are likely to do so in the near future
    - Funding and scheduling a health care provider to be available at the hospital for consultations
    - Reimbursement methodology (i.e. how are services billed in innovative payment models? Current fee-for-service CPT and ICD-9 codes will not work)
    - Risk management and liability issues
    - Technology investment
        - Upfront costs of hardware and software to deploy the infrastructure for the telehealth program, as well as ongoing maintenance
        - Long term care (LTC) facilities may be less technologically advanced than other health care entities and less equipped to initiate telehealth programs
- Members identified the following options for consideration when developing payment structures for incorporating the use of telehealth into non-fee-for-service payment structures:
    - Shared savings programs among hospitals, LTC facilities, and ambulatory physician practices
        - Hospitals could incentivize LTC facilities to reduce hospital admissions by partnering in a shared savings program
        - Telehealth could be used in cases where a physician is not available on-site
        - Identify needs that could best be addressed through telehealth, e.g. psychiatry, general medicine, dermatology
    - LTC facilities could join at-risk financial payment models; important that risk and reward are matched in business model
    - Providers could be incentivized to be on call to provide telehealth services; purchasing blocks of time
        - Purchasing blocks of time for specialties, such as dermatology and psychiatry, where scheduled visits occur, as well as in an emergency room setting where visits are not prescheduled
        - Payors could explore feasibility of purchasing block time; need to consider context of payment model, e.g. telehealth has been most effective in fully capitated models or online telehealth services directed at consumers
    - Would be informative to compare how services are currently delivered in the LTC setting, including transportation costs, with how similar services would be delivered using telehealth
        - Moving a patient with dementia or Alzheimer's can lead to additional complications; LTC facility staff may accompany the patient to the hospital; hospitals may have a nurse practitioner visit an LTC facility once a week

        - Health systems or hospitals may be interested in working with LTC facilities to provide them with telehealth technology and staff training; in many cases, current technologies can be adjusted for telehealth, e.g. cell phones, tablets

Next steps:

- *The MHCC will revise the table of innovative telehealth use cases financial and business model challenges and potential solutions based on the feedback received during the meeting; much of the feedback would apply to more than one use case*
- *The Finance and Business Model Advisory Group will continue to discuss business models for the innovative telehealth use cases at upcoming meetings:*
    - *Virtual meetings*
        - *Tuesday, June 17, 2014 from 11:00am – 12:00pm (dial: 866-247-6034; conference code: 6912847711#)*
        - *Wednesday, July 9, 2014 from 10:00am – 11:00am (dial: 866-247-6034; conference code: 6912847711#)*
    - *In-person meeting on Monday, July 21, 2014 from 2:00pm – 4:00pm at MHCC*