WashingtonState
TelehealthCollaborative

Meeting Minutes

September 11, 2023 | 10:00 am - 12:00 pm
Virtual Zoom Only Meeting

Member attendance					
Sen. Ron Muzzall	N	Dr. Josh Frank	N	Dr. Ricardo Jimenez	N
Sen. Annette Cleveland	Y	Joelle Fathi	N	Dr. Geoff Jones	N
Rep. Marcus Riccelli	Y	Stacia Fisher	Y	Scott Kennedy	N
Rep. Joe Schmick	Y	Dr. Frances Gough	Y	Mark Lo	Y
Dr. John Scott	Y	Lisa Woodley	Y	Heidi Brown	Y
Dr. Chris Cable	Y	Emily Stinson	N	Adam Romney	Y
Jae Coleman	N	Courtney Epps	Y	Cara Towle	Y
Stephanie Cowen	Y	Amy Pearson	Y	Lori Wakashige	Y
Kai Neander	Y				

Non-Member Presenters: Alpana Banerjee (unknown), Clark Hansen (ALS Association), Jennifer Kampsula Wong (Andy Hill Cancer Research Endowment Fund Board), Sarah Keogh (unknown), Jane Beyer (OIC), Joshua Liao (UWM), Edwin Wong (UWM), Jonathan Staloff (UWM), Jubi Lin (UWM), Hanna Dinh Hsieh (UWM)

Public attendees *(alphabetical by first name)*:
Al Hansell (CHPW/CHNW), Alex Wehinger (WSMA), Alexa Silver (Washington Academy of Family Physicians and Behavioral Health), Ashok Reddy (UWM), Barb Wayland (unknown), Brittainy Wittg-Valieva (FHCC), Cara Carlton (MultiCare), Caron Cargill (Hims & Hers), Carrie Tellefson (Teladoc), Chad Gabelein (MultiCare), Christopher Chen (HCA), Delika Steele (OIC), Gail McGaffick (WSPMA), Galen Alexander (Hims & Hers), Greg Attansio (unknown), Jaleen Johnson (NRTRC), Jeb Shepard (WSMA), Jennifer Zech (UWM), Jillian Kuba (UWM), Jim Freeburg (Patient Coalition of WA), Jodi Kunkel (HCA), Jonathan Staloff (UWM), Josh Viggers (UWM), Julie Hanson (Bluestone Psychological Services), Kathy Li (UWM), Kevin Gordan (WA Gov), Koji Sonoda (UWM), Kory (unknown), Leslie Emerick (WA State Hospice and Palliative Care), Maia Thomas (DCYF ESIT), Marissa Ingalls (Coordinated Care), Marshall Bishop (Bird's Eye Medical), Mercer May (Teladoc), Micah Matthews (WMC), Michele Radosevich (Davis Wright Tremaine), Mike Ellsworth (DOH), Mike Zwick (Cambia Health Solutions), Michelle Lin (UWM), Molly Shumway (UWM), Nancy Lawton (ARNPs United of Washington State), Nick S (unknown), Nicki Perisho (NRTRC), Nomie Gankhuyag (FHCC), Patrick Hastings (Bird's Eye Medical), Quinn Shean (Vice Chair of the Uniform Telehealth Act Committee), Rachel Abramson (UWM), Remy Kerr (WSHA), Sabrina Lin (UW), Sarah Huling (Ultrasound Tech)), Sarah Koca (CHPW/CHNW), Scott Sigmon (unknown), Shannon Thompson (WMHCA), Tom Holt (ZoomCare), Troy Di Lello (NVelUp Telehealth).

Meeting began at 10:00 am

Welcome and Attendance

Dr. John Scott [0:00]

Review of Meeting Minutes - July 17, 2023

Dr. John Scott [4:38]

Dr. Scott (Chair) reviews minutes. Dr. Mark Lo (Seattle Children's) motioned to approve minutes. Rep. Schmick (R-9) seconded. Unanimously approved as submitted.

Action Item:

- Mrs. Dinh Hsieh (Collaborative Program Manager) to post approved July 2023 notes on WSTC website

Patient Representative on the Collaborative

Dr. John Scott (UWM) [7:22]

Each of the four patient representative candidates introduced themselves and shared their experiences. Their biographies were shared with the group as shown below. Voting on accepting them as a patient representative on the Collaborative occurred as follows:

- **Alpana Banerjee**
    - After Alpana's postdoctoral research, she saw some changes in the behavioral and mental health issues in the school system and wanted to know the causes, prevention, and recovery of the kids and the adults in the school systems - this made her think of taking some mental health certifications. She took around 12 certifications on mental health from the National Council of Behavioral Health and Wellness from Washington DC. Alpana is also a certified Mental Health Instructor in Mental Illness & Drug Dependency (MIDD), King County, Seattle WA. Alpana has been involved in mental health for ten years now and understands the needs and rights of the patients in Washington State and fights to fulfill their needs when it requires a change in the policy. She would be happy to be a part of this team.

- **Clark Hansen**
    - Clark is the telemedicine expert for the Patient Coalition of Washington (PCW), uniting the state's leading patient groups to have one voice for better health care. The PCW is an independent, non-partisan coalition that works on Washington state policy issues. With

this experience, Clark can help advance a patient-focused telemedicine vision for the Collaborative. As the Managing Director of Advocacy for the ALS Association, he develops and implements advocacy campaigns that benefit the ALS community in eight western states. Clark has extensive health policy experience with strong relationships with Congress members and their staffs across the western states. He served as a senior policy advisor on Medicaid and long-term care issues to the Connecticut State Senate, worked in provider and government relations for the Connecticut Behavioral Health Partnership, and was the West Coast representative of Bread for World - a national non-profit working to improve national and state level nutrition policy. He also is Vice President of the Board for Columbia Valley Community Health – North Central Washington's FQHC.

- **Jennifer Kampsula Wong**
  - Jennifer Kampsula Wong was appointed by Governor Inslee as a founding member of the Andy Hill Cancer Research Endowment (CARE) Fund board of directors and serves as a patient advocate. After eleven years of practicing law as a civil litigation attorney, Jennifer transitioned to the development field as the Director of Gift Planning with a nonprofit. In this role, she was able to work with individuals that care about the future of communities while utilizing her legal background and community service experiences. Her law practice has provided her with strong research and analytic skills, as well as a keen sense for identifying issues and addressing challenges through dynamic, strategic planning. As an ambassador with the American Cancer Society's Cancer Action Network, she currently pursues her passion for public policy and legislative affairs at the local, state and national levels.

- **Sarah Keogh**
  - As we bring on more patient advocates to the Collaborative, having the voice of a proxy/parent/guardian may help round out the different perspectives. Sarah has 3 children with medical needs and has gone to over 100 appointments per year at Seattle Children's as well as traveling to other states for care. She uses telehealth frequently and expertly for both Seattle Children's and other hospital appointments and she experienced first-hand the benefits and challenges of telehealth. Sarah also has experience of healthcare in both Ireland and the UK.

There was a majority vote of 9 votes from the Collaborative to accept Sarah Keogh as the patient representative for the Collaborative. The votes for the remaining candidates were as follows:

- Clark Hansen received 6 votes
- Alpana Banerjee received 0 votes
- Jennifer Kampsula Wong received 0 votes

Action Item

- Mrs. Dinh Hsieh (Collaborative Program Manager) to update Collaborative membership roster

State/Federal Updates

Hanna Dinh Hsieh and Dr. John Scott (UWM) [24:46]

- Washington Health Care Authority Medicaid resources on devices and software for telehealth use
    - Cell & Internet service and devices are available through the Lifeline program.
    - Zoom licenses can be requested by providers to connect with patients – current licenses run through March 15, 2024
- The Drug Enforcement Administration (DEA) is holding public listening sessions to gather feedback on whether to allow telemedicine prescribing of certain controlled substances without in-person medical evaluations and how to prevent their diversion.
    - The sessions are on September 12-13, held in-person and remotely
    - Details for the remote session will be publicized at a later date

Questions/Discussion:

- Dr. John Scott adds that the DEA public listening sessions are related to the Ryan Haight Act where there is currently a 6-month grace period, but there are many opinions in having a more permanent solution. These sessions are a great opportunity for folks who work with those getting controlled substances and to share your perspectives at this forum.

Uniform Telehealth Bill Follow-Up Discussion

Senator Cleveland (49th District) [28:13]

Goals of the Uniform Telehealth Act

- To improve access to care through greater use of telemedicine and the number of providers allowed to treat patients through telemedicine
- To create uniformity in the definition of telemedicine and the technology used to provide care across states

Section by section review of the 2023 bill and substitute bill

Section	SB 5481	SSB 5481
2: Definitions	Establishes definitions include defining "out-of-state healthcare practitioner" and "registered healthcare practitioner"	Removed definitions related to out-of-state and registered practitioners, added a definition of store and forward technology, and added "store and forward" as part of the "telemedicine services" definition

3: Scope	The bill applies to telemedicine services provided to patients located in WA only	No change
4 & 5: Telemedicine authorization and practice standards	A licensed provider may provide telemedicine services consistent with their scope of practice, provided that the services meet the same practice standards as providing in-person care	No change
6: Out-of-state healthcare practitioners	Allows out-of-state practitioners to provide telemedicine services to WA residents if: • They are licensed in WA; • They complete a registration process established in the bill; or • The service is in the form of a consultation with a provider who has a patient-provider relationship with the patient or for a specialty diagnosis or treatment recommendation	Maintained this section but removed the reference to the registration process
7: Registration	Requires disciplinary authorities to register out-of-state practitioners if they meet certain requirements, allowing them to provide telemedicine in WA	Removed the entire section
8: Discipline	Authorizes disciplinary authorities to discipline registered practitioners	Removed the entire section
9: Duties of registered practitioners	Requires registered practitioners to report disciplinary action, maintain insurance, and prohibits opening an office in the state	Removed the entire section
10-13: Other provisions	These sections relate to venue for lawsuits, rulemaking	No changes

	authority, statutory construction, and severability	

Outstanding Issues

- Whether Washington should adopt a registration system for out-of-state providers to provide telemedicine services to Washington residents
- Whether a patient-provider relationship may be established though telemedicine
  - Language allowing this was not included in the Senate bill
- Whether a disciplinary authority may adopt rules that establish a different professional practice standard for telemedicine services or limits the types of technology that may be used for telemedicine services
  - Language prohibiting authorities from establishing such rules was not included in Senate bill

Questions for the Collaborative

- Does the Collaborative recommend adopting a registration process as proposed in the bill, and if so, would additional safeguards to address patent safety and quality of care concerns be needed?
- Does the Collaborative recommend allowing a patient-provider relationship to be established through telemedicine?

Questions/Discussion:

- What is the status of the report that the legislators tasked the University of Washington to look into for audio-only telemedicine?
  - The report will be presented in the next agenda item.
- Does the Washington Medical Commission (WMC) have any concerns from the perspectives of enforcement or quality of care?
  - Micah Matthews (WMC) responds that they have an existing policy on the ability to establish a patient relationship via telemedicine. Compared to their national peers, WMC has not limited the prescribing ability of their practitioners as long as the patient safety issues are addressed. For example, with established patients, practitioners can prescribe opioids and other controlled substances. They have not seen a telemedicine-centric issue around this.
  - Micah Matthews (WMC) adds that with respect to the registration, currently there are multiple pathways to licensure for physicians and for physician assistants. This includes the Department of Health online version, the Federation of State Medical Boards (FSMB) online application, and the Interstate Medical Licensure Compact.
    - If the compact for physician assistants is established with seven boards adopting, there will be a third pathway for them.
    - An audit was recently completed where it was looking at licensure and disciplinary processes along with their respective timelines – this was found to be acceptable.

        - There is a running monthly timeline for issuing licenses, which generally ranges from four to five weeks. During the peak season, WMC goes to six weeks from the submission of a standard license (submission via FSMB or WMC).
        - Regarding the compact, if a practitioner asks for a reciprocal license (i.e. getting a license through the compact and you already have a state of principal license in another state), they will receive this in five days or less. If Washington is the desired state for the state of principal license, WMC has 30 days to provide the practitioner this license.
- At the onset of the pandemic, were the licensing timelines the same as they are currently at WMC (four to five weeks to license on average)?
    - The pandemic did exacerbate the timelines because during the pandemic, staff were rotating between working remotely and in the office as WMC was a paper-based office for licensing. This prompted the WMC to transition to a paperless system and now, staff were working mostly remotely with a few staff going in to the office at least once a week – this helped to continue to maintain the existing timelines.
    - The other complicating factor was the Volunteer Healthcare Practitioner Act – this was the main vehicle that got more of the border states in. The WMC staff validated 9000 licensees into Washington through this Act using docinfo.org, which is the national FSMB public provider credential search.
    - Dr. John Scott adds that with UW Medicine's experience, the most challenging item with applying for licensure through the Interstate Compact is getting fingerprinted, which can delay the application process.
        - One of the considerations of the WMC audit was to reconsider use of fingerprints for non-Interstate Medical Licensure Compact applicants.
        - WMC generally uses fingerprinting for most out-of-state folks, and less than one percent return with hits.
        - Dr. John Scott also shares that there are privacy concerns with fingerprinting and concerns with how this information is stored. However, the fingerprinting structure is in the Uniform Disciplinary Act where this applies to all health care practitioners.
- Does the Collaborative recommend allowing a patient-provider relationship to be established through telemedicine?
    - Dr. Mark Lo (Seattle Children's) responds that he'd be in favor of this as it has implications for payers, for billing, for federal, for DEA, etc. Overall, from an access standpoint, his priority would be implications to those who cannot get access to healthcare, which he'd be in favor of the patient-provider relationship being established via telemedicine.
- For out-of-state scenarios in Washington, is there a current state feedback system where if there happens to be a revoked licensure or disciplinary action, is this communicated amongst all the different callback states or the different states that the provider has a license in?
    - For practitioners who have a lot of licenses, this is commonly called the domino effect. In the compacts, there is a mandated information sharing system and all this information is

shared under a seal of confidentiality. This allows joint investigations to be conducted and there is a coordinated response system. For example, if a practitioner's state of principal license was suspended or revoked, all of the other licenses that were based on this state of principal license is made inactive as well because this license is one's entry into the compact.
    - On the other hand, the FSMB has a massive database of practitioners, their demographics, where they're licensed, etc. When an FSMB member (like WMC) sends a disciplinary document to the FSMB, they send a notice to all the various state medical boards where the practitioner is licensed.
    - There is also the National Practitioner Database (NPDB), which one can subscribe to or can have more responsive queries to it. If there is a notice for a disciplinary action, it goes through a complaint process and WMC pulls a NPDB report – this can include hits from law enforcement, hospital credentialing, etc.
- What highlights would the Washington State Medical Association like to share from a physician perspective?
    - Alex Wehinger (WSMA) shares that it's important for providers to be fully vetted in order to provide safe and quality care to Washington State residents and it's through the licensure process. In regards to the patient-provider relationship being established through telemedicine, she comments that telemedicine is of most value when it's augmenting rather than replacing in-person care. It's also important to reconcile what's proposed in this bill with the state's extensive statutory telemedicine framework that was established by the legislature before the pandemic.
- What highlights would the Uniform Telehealth Act Committee like to share from this perspective?
    - Quinn Shean introduces herself as the Vice Chair of the Uniform Telehealth Act Committee. This policy was a three-year process bringing together stakeholders from all across the healthcare continuum. The Committee believes that what passed out of the Uniform Telehealth Act is the best of telehealth policy across the country in a single framework that will make it easier to deliver telehealth across state lines, but also to retain the authority of the individual states to discipline providers and promote patient safety.
    - Regarding the registration model, different Boards and professions have different experiences with what it takes to deliver care in the state. The Committee convened a study on what the process should be for out-of-state practitioners, and they looked at many different models. They believe that there needs to be a balance between patient access and patient accountability. They also believe that based on the registration model that other states had implemented, including Arizona and Florida, this provides an additional pathway alongside the compacts and the continuity of care.
    - Regarding the patient-provider relationship to be established through telemedicine, Quinn shares that telehealth is one mode of delivering care and it is appropriate for patients some of the time, but not all of the time. This is similar to other types of care delivery that are not appropriate for patients all the time.

    - The Committee believes that it's important to explicitly make this statutory authorization clear. Quinn is not aware, unless something has changed, of any state that precludes forming at least a medical relationship via telehealth across the board.

Action Items

- If the Collaborative members have any further questions or have additional comments, reach out to Senator Cleveland at annette.cleveland@leg.wa.gov and her legislative assistant, Kevin Gordon at kevin.gordon@leg.wa.gov as well as Quinn Shean at quinn.shean@gmail.com.

House Bill 1196: Cost Impact of Audio-Only Telemedicine Background Jane Beyer (OIC) [57:20]

- Beginning in 2015, the Washington State Legislature, with collaborative input and support, has incrementally expanded and made permanent coverage of telehealth services.
- When regards to health insurance plans and requirements on health insurers, there are two types of broad health plan
  - Those that are fully insured where an employer or a state/local government as an employer says to an insurance company that they're going to pay a monthly premium for the insurance company to bear all of the financial risk. In other words, if their patients' or employees' claims cost more than the premium quoted, this is on the insurance company. These are the health plans that the Office of the Insurance Commissioner has the authority to regulate under state law.
  - About two-thirds of the people who have health insurance through their employers' health plans get these benefits from self-funded health plans. Self-funded health plans are where a large enough employer can bear a large amount of the financial risk of their employees' health care costs. Under a federal statute called the Employee Retirement Income Security Act (ERISA), which was passed in 1973, states and state legislatures cannot, with one exception, regulate the benefit plans of those self-funded group health plans. These health plans are only subject to federal laws and not the telemedicine coverage law.
    - For example, during COVID-19 when Congress was enacting statutes around expanding telemedicine use and the additional benefits that they want to provide for folks, Congress had the authority to tell both self-funded and fully insured health plans that they had to comply; state legislatures do not have this authority.
    - When the state legislature enacted the comprehensive legislature structure around telemedicine, this applies to 1.3 million people who get their coverage through fully-insured health plans. This includes people who are buying health plans in the individual market, on the exchanges, as well as in small employer health plans and large group health plans that choose fully insured approaches to provide benefits to their employees.

- The legislature also has authority over Public Employee Benefit programs (e.g. state and university employees, school employees, etc.) – they can set the rules for these plans. They can also regulate the state Medicaid program.
- If you tally up the 1.3 million that are enrolled in plans that the Office of the Insurance Commissioner can regulate, the 2 million people covered by Medicaid, and about 750,000 people that are covered under PEB or SEB program, this is about half of the state.
- The legislature did a series of incremental expansions with the most significant in 2021 when it enacted House Bill 1196. In relation to the definition of audio-only telemedicine, it required that health insurers, PEB, SEB, and Medicaid to reimburse providers for health care services provided through audio-only telemedicine under the same conditions applicable to audio-video telemedicine. This is with the exception of requiring that there be patient consent obtained before an audio-only telemedicine service is covered and also including an established relationship provision. This provision was amended again in 2022 and 2023 based upon the Collaborative recommendations.
- In 2021, when the legislature authorized coverage of audio-only telemedicine, unlike other states that limited this authorization to the period during the pandemic, the legislature made this law permanent.
    - There were questions that came up in 2021 around the consequences of having a permanent extension of audio-only telemedicine benefits, when House Bill 1196 was being debated. As a result of this, Section 8 of the legislation included a directive to the OIC, the Washington State Telehealth Collaborative, and the Health Care Authority to submit a report to the legislature by November 1, 2023 to study and make recommendations on several issues:
        - Preliminary utilization trends for audio-only telemedicine
        - Obtain qualitative data from health insurers, including Medicaid Managed Care Organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine.
        - Have preliminary thoughts regarding incidents of fraud to provide proposed methods to measure the impacts of audio-only telemedicine on access to health care for historically underserved communities and geographic areas. This is to develop an evaluation of the relative costs to providers on audio-only telemedicine and to raise any other issues and make any recommendations to the legislature.
- The biggest challenge in having the legislature enact a provision in 2021 that authorized coverage of audio-only telemedicine and having a report due date of November 1, 2023, is that this only gives folks a beginning of an analysis look, but doesn't give a comprehensive look. In healthcare, providers have a year to submit claims and it takes a while for claims to be submitted by carriers.
- The OIC, the Collaborative, the HCA Medicaid program opened up discussions with Dr. Liao's VSSL team to determine what components can they have in a study to help inform those issues that the legislature was seeking information on. This was divided into four components:
    - Used Washington state's all-payer claims database to do a deep dive analysis with respect to utilization of audio-only telemedicine across Medicaid and Commercial health plans.
    - OIC fielded a survey of health carriers and Medicaid Managed Care Organizations

  - VSSL team did a comprehensive literature review to look at recent, reliable research and evidence on regulatory experience, cost, and clinical effectiveness of audio-only telemedicine.
  - VSSL team developed recommendations related to methods in measuring the impact of access to audio-only telemedicine on the underserved populations and concerned communities

Action Items

- If the Collaborative members have any further questions, reach out to Jane Beyer at jane.beyer@oic.wa.gov.
- Collaborative members to send feedback on the draft report on audio-only telemedicine by September 19th via an OIC email inbox.

House Bill 1196: Cost Impact of Audio-Only Telemedicine Updates

Dr. Joshua Liao (UWM) and Value & Systems Science Lab (VSSL) Team [1:08:44]

Outline

- Overview of Audio-Only Telemedicine Evaluation
- ESHB 1196 Components and VSSL Scope of Work
- Findings
- Summary
- Q&A

Audio-Only Telemedicine Evaluation

- Section 8 in ESHB 1196 (hereafter, "1196" directed the Office of the Insurance Commissioner (OIC), in collaboration with the Washington State Telehealth Collaborative and the Health Care Authority (HCA), to undertake a study related to audio-only telemedicine and report findings of the study to the legislature by November 1, 2023.
- VSSL (Value & Systems Science Lab) at the University of Washington School of Medicine was engaged to assist with this directive.

ESHB 1196 Components and VSSL Scope of Work

ESHB 1196 Section 8 Components	VSSL Activities
Preliminary utilization trends for audio-only telemedicine	Analysis of Utilization Trends in Audio-Only Telemedicine Using Claims Data (Jan-Nov 2022)
An evaluation of the relative costs to providers and facilities of providing audio-only telemedicine services as compared to audio-video telemedicine services and in-person services	Literature Review • Regulatory experiences, costs, clinical effectiveness • Costs assessment based on available CPT, RVU-based estimates
Preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud	
Qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine	Web-Based Survey of Commercial Carriers and Medicaid Managed Care Organizations
Proposed methods to measure the impact of audio-only telemedicine on access to health care services for historically underserved communities and geographic areas	Proposed Methods to Measure the Impact on Access to Health Care Services for Historically Underserved Communities and Geographic Areas

- This information was previously presented at the Telehealth Collaborative Meeting (9/19/2022) and Interested Parties Webinar (10/10/2022)

All Payer Claims Database (APCD) Analysis

- Identification of audio-only telemedicine use
  - Primary Approach: new CPT code modifiers (FQ, 93) effective 1/1/2022 + selected CPT codes (e.g., 99441-99443; 98966-98968)
  - Secondary (CR modifier) and tertiary (GT and 95 modifiers) approaches were used to provide alternative perspectives on audio-only telemedicine services

Trends Analysis Finding 1 (Primary Approach)

- Audio-only telemedicine utilization remained stable overall but varied by beneficiary population
  - Utilization varied by age, gender, payer type, and urban/rural residence
  - Older, female, Medicaid-insured, and urban-dwelling beneficiaries had higher proportions of utilization than might be expected based on their representation in the population
  - Utilization varied slightly by the extent of social vulnerability in beneficiaries' areas of residence

Trends Analysis Finding 2 (Primary Approach)

- Audio-only telemedicine was used most commonly for mental health conditions
  - Audio-only telemedicine was used most commonly for post-traumatic stress disorder, generalized anxiety disorder, unspecified anxiety disorder, and major depressive disorder
  - These findings may reflect the importance of audio-only services for behavioral health and/or new claims-based methods to identify audio-only services for behavioral health needs

Trends Analysis Finding 3 (Primary Approach)

- Over time, the amount of audio-only telemedicine delivered by physicians and advanced practice providers was surpassed by the amount delivered by other providers.
  - The amount of audio-only telemedicine delivered by providers such as psychologists and licensed independent clinical social workers exceeded the amount delivered by physicians and advanced practice providers (e.g. nurse practitioner, physician assistant)
  - Together with Finding 2, this trend may reflect a growing number of behavioral health providers delivering audio-only telemedicine

Trends Analysis Finding 4 (Primary Approach)

- Audio-only telemedicine was rarely delivered by telemedicine-only providers
  - Telemedicine-only providers deliver services through telemedicine modalities exclusively
  - These providers comprised a small percentage of all providers and provided a low proportion of audio-only telemedicine services

Trends Analysis Finding 5 (Primary Approach)

- Audio-only telemedicine was varied geographically, with certain areas demonstrating low use compared to others
  - Several counties in the southeastern part of Washington exhibited low levels of audio-only telemedicine (Asotin, Columbia, Adams counties)
  - Higher use areas were more geographically dispersed across the state

Literature Review

- Systematic Review
  - 3 domains: Regulatory Experiences, Costs, Clinical Effectiveness
  - Multi-step process conducted to maximize rigor and thoroughness
  - 2,503 articles screened; 71 articles included
- Additional Review
  - Conducted as complement to systematic review
  - Based on a search of materials from a set of organizations and groups
  - 60 articles included

Literature Review Finding 1

- Association between audio-only telemedicine and improved access to care has been documented
  - Certain populations were more likely than others to use audio-only services:
    - Racial and ethnic minorities
    - Geographically remote communities
    - Individuals who were uninsured
    - Individuals who were non-English speaking or had limited English proficiency
    - Individuals with limited digital literacy or transportation difficulties
  - Expanded insurance coverage and reimbursement contributed to improved health care access, especially among vulnerable patient populations

Literature Review Finding 2

- There is compelling evidence in a range of settings for the association between audio-only telemedicine and improved clinical outcomes
  - Numerous articles – most reporting on work done prior to COVID-19 – assessed the relationship between audio-only telemedicine and clinical outcomes for a range of behavioral and physical health conditions
  - Over 80% of articles reported positive associations between audio-only telemedicine and clinical outcomes

Literature Review Finding 3

- Association between audio-only telemedicine and cost savings differed from patient and payer perspectives
  - Relative to in-person visits, audio-only telemedicine was associated with patient cost savings, largely derived from lower travel expenses

  - There was mixed evidence on provider and payer cost savings

Cost Review

- Relative Value Units (RVUs)
  - Units that reflect the extent of physician work and resources needed to deliver particular health care services
  - There types of RVUs
    - Work (WRVU)
    - Practice Expense (PE RVU)
    - Malpractice (MP RVU)
  - WRVU: Difficulty, time, effort, and expertise associated with a clinical service
  - PE RVU: Cost of clinical and nonclinical labor expense to the practice as well as medical and office supplies/equipment
  - MP RVU: Professional liability insurance cost based on the risk associated with a service
  - RVUs are converted into dollars that form the basis of clinician reimbursement
  - CMS published a fee schedule based on RVUs, which are then used by other payers to establish reimbursement

Cost Review

- Reviewed RVUs and corresponding dollar amounts for these collections of CPT codes between 2019 and 2022 to compare pre-pandemic and pandemic view of costs
- Costs are compared between 2019 and 2020 to highlight reimbursement changes before and after the pandemic
  - Looking at the total reimbursement of audio-only telemedicine in 2019, the cost was about $40. For audio-visual telemedicine, the reimbursement only began after the pandemic in 2020 – so there are no comparisons with this in 2019. For in-person visits, the total reimbursement was roughly doubled to tripled the cost of audio-only telemedicine.
  - The difference between facility and non-facility costs is in terms of the project suspense RVU. The total facility cost is generally lower than non-facility costs because in a facility setting (e.g. hospital), the cost of supplies and personnel that assist with services are covered by the hospital whereas those same costs are formed by the provider of services in a non-facility cost.
  - In 2020, under revised rules from the CMS payment for audio-only telemedicine, this was matched to office visits. Reimbursement for audio-only telemedicine doubled to tripled from $40 to match payments for office visits.

	Audio-Only (CPT 99441-99443)	Audio-Video (CPT 99212-99214 + modifiers)	In-Person (CPT 99212-99214)
Example CPT Code	99443	99214	99214
Total Reimbursement (2019)			
Facility	**$38.92**	-	**$80.01**
Non-Facility	**$40.36**	-	**$110.28**
Total Reimbursement (2020)			
Facility	**$80.48**	**$80.48**	**$80.48**
Non-Facility	**$110.44**	**$110.44**	**$110.44**

Between 2020 and 2022, under revised rules from CMS, reimbursement values for CPT 99441-99443 were matched to values for CPT 99212-99214.

- The below chart is zooming in to look at RVUs that determine total reimbursement. Like the previous chart, this will compare pre-pandemic and pandemic costs of audio-only telemedicine to office visits.
- For audio-only telemedicine, all RVUs increase after the pandemic.
- Most significantly, work RVUs doubled from roughly $27 to $54, comparing pre and post pandemic costs.
- Practice expense RVUs for facility costs also doubled from about $10 to 22 and more than quadrupled for the non-facility costs from $11 to $52.
- For office visits, the total reimbursement remained relatively stable over time.
- Comparing the pandemic costs of audio-only telemedicine in 2020 when payment parity was initiated under revised CMS rules, all RVUs used to determine total reimbursement all matched between audio-only telemedicine and office visits.

	Total	Work	Practice Expense	Malpractice
Audio-Only (CPT 99441-99443)				
Example CPT Code 99443				
Reimbursement (Pre-pandemic*)				
Facility	**$38.92**	$27.03	$10.45	$1.44
Non-Facility	**$40.36**	$27.03	$11.89	$1.44
Reimbursement (Post-pandemic**)				
Facility	**$80.48**	$54.14	$22.38	$3.97
Non-Facility	**$110.44**	$54.14	$52.33	$3.97
In-Person (CPT 99212-99214)				
Example CPT Code 99214				
Reimbursement (Pre-pandemic*)				
Facility	**$80.01**	$54.06	$22.34	$3.60
Non-Facility	**$110.28**	$54.06	$52.62	$3.60
Reimbursement (Post-pandemic**)				
Facility	**$80.48**	$54.14	$22.38	$3.97
Non-Facility	**$110.44**	$54.14	$52.33	$3.97

Between 2020 and 2022, under revised rules from CMS, reimbursement values for CPT 99441-99443 were matched to values for CPT 99212-99214. *2019. **2020.

Terms to Review

- ESHB 1196 Audio-Only Telemedicine Policies
  - Patient Consent
  - Established Relationship
  - Facility Fee
- Telemedicine-Only Providers vs. Brick-and-Mortar Providers
- Physical Health vs. Behavioral Health Providers

Web-Based Survey

- Final Survey Domains
  - Background Questions
  - Enforcement requirements and compliance burden
  - Observations about fraud incidence and audits
  - Differences in audio-only telemedicine services between telemedicine-only and brick-and-mortar providers
  - Impact of audio-only telemedicine on value-based payment arrangements or value-based care programs

Web-Based Survey Finding 1

- Audio-only telemedicine was used across many different types of care
  - Mental health and substance use disorder services
    - Including behavioral health treatment
  - Preventive and wellness services and chronic disease management
  - Pediatric services
    - Including oral and vision care
  - Emergency services
  - Maternity and newborn care

Web-Based Survey Finding 2

- Carriers perceived that providers were aware of audio-only telemedicine laws (Patient Consent, Established Relationship, Facility Fee). Monitoring for provider compliance with these laws occurred infrequently
  - Factors contributing to infrequent monitoring:
    - Lack of automated systems
    - Labor-intensive process
    - Existence of contracting processes that address compliance
    - Lack of requirement to monitor for compliance

Web-Based Survey Finding 3

- Carriers frequently did not conduct fraud audits related to audio-only telemedicine laws (Patient Consent, Established Relationship, Facility Fee). Carriers generally perceived that fraud occurred infrequently
  - For each law, half or more carriers did not perform fraud audits of providers
  - Among other carriers:
    - The general perception was that fraud occurred rarely or never
    - In some instances, carriers perceived fraud occurring sometimes or often

Web-Based Survey Finding 4

- Carriers perceived some differences between telemedicine-only and brick-and-mortar providers
  - Carriers had similar perceptions of fraud incidence among brick-and-mortar and telemedicine-only providers
  - Some carriers perceived that compared to brick-and-mortar providers, there was better access to care and technology for audio-only telemedicine services through telemedicine-only providers, but at the potential risk of lower safety
  - Carriers had mixed perceptions about differences between telemedicine-only and brick-and-mortar providers with respect to:
    - Clinical effectiveness
    - Equity
    - Patient costs

Web-Based Survey Finding 5

- Amid perceived challenges and opportunities, no carriers have incorporated audio-only telemedicine in value-based purchasing and care
  - Challenges:
    - Appropriate billing codes and modifiers
    - Lack of a physical exam component
    - Risk adjustment
    - Perceived limited use of telemedicine in closing quality care gaps
    - Varying provider capacity and patient preference in using audio-only telemedicine
    - Patient attribution to clinic based on audio-only telemedicine use
  - Opportunities:
    - Improved access to care
    - Reduced cost
    - Improved quality of care

Measure Impact on Access

- Proposed three potential evaluation options
- Options span a range of potential quantitative and qualitative evaluation methods
  - Analysis of WA-APCD claims data
  - Patient access survey

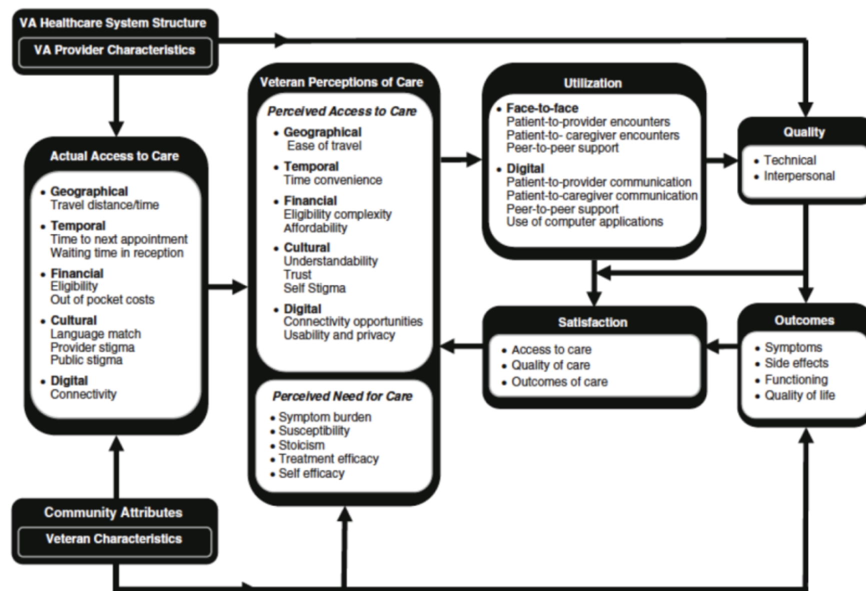
- Qualitative analysis (e.g., interviews, focus groups)

- The chart below provides a high level overview of the three evaluation options that integrate the three components mentioned previously.

	Option 1: Foundational	Option 2: Expanded	Option 3: Comprehensive
Questions Answered	How does audio-only telemedicine (AOTM) impact health care access for Washingtonians? How does this impact vary for historically underserved communities and areas* versus others?		
		How does this impact vary by method of defining access?	
			What are barriers and facilitators to AOTM use and experience? How do they vary for historically underserved groups/areas?
Work Involved	Analysis of Washington State All-Payer Claims Database (WA-APCD) data †		
		+ Patient access survey	+
			+ Qualitative analysis (e.g., interviews, focus groups)
Timeline	12 months	18 months	24 months

*Defined in detail in text of proposed methods as communities & areas to study will vary by option, † Analysis of state-wide claims using advanced statistical methods

- To delve deeper into the access component, one of the key observations through VSSL's prior work is that access is not uni-dimensional. Access contains a number of different sub components and dimensions that VSSL recommends would be important to elucidate in any future evaluation. Below is a conceptual model of access that is developed in a prior Journal of General Internal Medicine article in 2011. While this was initially for a VA population, VSSL believes that there's some real key direct takeaways for Washington State's population.



Conceptual model of access from Fortney, et al. (2011), *Journal of General Internal Medicine*

Potential Implications

- Audio-only telemedicine use has varied across groups in ways that may promote equity
- Audio-only telemedicine may be poised to treat and improve outcomes for behavioral health conditions
- Audio-only telemedicine may save costs for patients
- New policies or requirements may be needed to monitor for provider compliance with audio-only telemedicine laws, which rarely occurs currently
- There are perceptions among some carriers that telemedicine-only providers may differ from brick-and-mortar providers with respect to:
    - Access to audio-only telemedicine care and technology (greater with telemedicine-only providers)
    - Safety (worse with telemedicine-only providers)

Future Work

- **Evaluate how audio-only telemedicine affects access among historically underserved communities and areas.** Despite some suggestive evidence that audio-only telemedicine can improve equity, formal evaluations are urgently needed. Options include approaches proposed by VSSL.
- **Evaluate how audio-only telemedicine affects provider and payer costs.** Literature review conducted by VSSL underscores how audio-only telemedicine can save costs for patients. However, evidence was too limited to draw conclusions about hospital or payer costs, which could be the focus of future evaluations.
- **Evaluate for differences between telemedicine-only and brick-and-mortar providers.** The survey fielded by VSSL showed that carriers perceive certain differences between telemedicine-only and brick-and-mortar providers. Evaluation is needed to asses and quantify differences.
- **Incorporate audio-only telemedicine into value-based purchasing and care.** The survey fielded by VSSL suggests that little work has occurred thus far to integrate audio-only services into value-based purchasing and care. This is a high priority opportunity.

Questions/Discussion

- When it was noted that utilization rates remained roughly stable, what time period was this compared to?
    - By stable, it meant the count of audio-only telemedicine visits was largely similar across months in 2022
- Regarding the cost piece, in addition to looking at 2019 and 2020 cost estimates, was there an examination of how 2022 costs compare?
    - There was a comparison of costs between 2019 and 2022, but only showed comparisons between 2019-2020 today as the costs after the pandemic (2020-2022) remained relatively stable for audio-only telemedicine and office visits.

- Can you confirm that the findings are not out of line with what is typically seen with fraud regarding audio-only telemedicine and reimbursing this way (e.g. no significant spikes)? What is the actual perception vs. outcomes as we go forward in unraveling this more?
    - Audio-only telemedicine, from the perspective of the all-payers claims database, has been challenged by: "can we identify it, is what we see normal during the pandemic and coming out of the pandemic, etc" The next step and next phase of work would be to set up outcomes related to not just access, but safety clinical outcomes and others.
    - There wasn't a huge, systematized method where fraud was being continuously monitored for at scale. Understanding this caveat, among those who did monitor for fraud, the overall perception is that fraud occurred infrequently. There was no perception that audio-only telemedicine was a fraud-free mechanism of delivering care, but no mechanism of delivering care is viewed as fraud-free. Of those who did monitor, they didn't feel that audio-only telemedicine was a special breeding ground for fraudulent activity.
    - Micah Matthews (WMC) adds that on the compliance issue from the regulatory perspective, the WMC anecdotal experience has shown minimal telemedicine issues based on their disciplinary actions over the past three years. Where they do see compliance/fraud is when insurers audit and find concerns that they refer to us. Example being a controlled substance prescription costing less than $20 and a telemedicine prescriber utilizes a legend drug that costs thousands of dollars. They consistently see issues around "creative" care models that attempt to utilize unlicensed "navigators" or dynamic forms that minimize or exclude direct contact with the practitioner completely from the patient. These models are easy to investigate and WMC's mantra is always the licensee needs to be seeing the patient and determining that the telemedicine format is appropriate for the encounter based on their needs.
- At some point, are we able to drill down to see if more encounters are occurring because people are using audio-only telemedicine? Is this beneficial or only adding more encounters?
    - Since the Legislature is cautious about Medicaid Program Integrity, can the HCA speak to what they're looking at?
    - The big caveat is that this was a survey of Managed Care Organizations and insurers, which may not be reflective on what the state is seeing in terms of either referrals or monitoring activity.
    - Some of the carriers weren't conducting in-depth audits – sometimes fraud comes up when you're looking for it. Drawing large generalities from the survey may be difficult.

Action Items

- Collaborative members to send feedback on the draft report on audio-only telemedicine by September 19th via an OIC email inbox.

WashingtonState
TelehealthCollaborative

Wrap Up/Public Comment Period

[1:57:35]

- Next meeting: Monday, November 13, 2023 at 10:00 am – 12:00 pm
- Meeting materials, including presentation slides and recording, will be posted on the Collaborative's website and sent out via the newsletter
- Alpana Banerjee (unknown) asks what are the barriers and facilitators to audio-only telemedicine use and experience? How do they vary from historically underserved groups/areas?
    - The literature review helped to identify those barriers and facilitators. But for historically underserved groups/areas, this is aimed to be explored in the future work. Analyzing claims data is great, but what you lose in the claims data is this granularity, which is to be further investigated in the next phase of work.

Action Items

- Collaborative members to share agenda topics for future Collaborative meetings and email them to Dr. Scott / Mrs. Dinh Hsieh

Tentative Next Meeting Items:

Thriving Together's Telehealth Efforts
EvergreenHealth's Telehealth Experience
Health Resources and Services Administration (HRSA) Federal Telehealth Resources
Northwest Regional Telehealth Resource Center (NRTRC) 2024 Conference

Meeting adjourned at 12:00 pm

Next meeting: November 13, 2023: 10 am-12 pm
Via Zoom.