WashingtonState
TelehealthCollaborative

Report of the Washington State Telehealth Collaborative

December 2018

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Executive Summary

The Washington State Telehealth Collaborative was formed in 2016 as a result of *SB6519* and with a mission to provide a forum to improve the health of Washington residents through the collaboration and sharing of knowledge and health resources statewide and increasing public awareness of telehealth as a delivery mechanism. In the last year, the collaborative has met eight times and focused on three areas: 1) training providers on telemedicine; 2) cost-effectiveness of telemedicine; and 3) payment parity. Many of the large health systems have standardized training but there is no widely available, low-cost training available for smaller practices or solo clinicians. Members of the collaborative have established a set of PowerPoint slides that can help these providers. It covers topics such as billing and coding, patient consent, malpractice, webside etiquette, documentation, and privacy issues. The collaborative is exploring the best ways to disseminate this training.

On the topic of cost-effectiveness, the collaborative learned that data collection on cost-effectiveness can be quite difficult and one's perspective on the analysis matters. For example, a particular type of telehealth program may be cost-effective from a patient or societal perspective, but not from a health system perspective. There is quite a diversity of opinion on the question of whether telemedicine is cost-effective.

Payment parity is the idea is that a clinician should be paid the same amount for a clinical service provided through telemedicine as an in-person. There was agreement that telemedicine visits could be billed using Current Procedural Terminology (CPT) does with associated telemedicine modifiers ((as opposed to the 9944x "Internet" codes). However, some members believed that telemedicine visits may not be equivalent clinically to an in-office visit, that the overhead costs can be lower and that one purpose of the technology is to lower the cost of health care. This is supported by the RVU's that CMS has created. Other members disagreed, saying that there are other overhead costs (such as software, hardware, IT help, clinical staff and office space) which need to be accounted for, that telehealth can be used with peripheral devices and with trained telepresenters who assist in a physical exam, and that reimbursement is already quite low for in-person visits. The discussions for payment parity were limited to synchronous video visits. It was recognized that store and forward visits can be very different and payment parity was not discussed in detail for this type of care. In summary, the collaborative could not agree on conditions of payment parity pilot and some health systems stated that they would not participate in such a pilot.

Meeting Times and Locations

The collaborative met eight times in 2018, rotating meeting locations around the state in order to accommodate the broad geographic representation. Each meeting was at least two hours. Sessions were open to the public and the public's questions, comments, and suggestions were considered in the development of this report. Please see the following table for meeting days and locations.

Date	Location	Topics

January 5, 2018	Kaiser Permanente Renton, WA	• Cost/Outcomes • Report to Legislature • Net Neutrality • Parity http://www.wsha.org/wp-content/uploads/MINUTES_WA-State-Collab-01.05.18.pdf
March 23, 2018	University of Washington Medical Center Seattle, WA	• Malpractice • Passed Legislation Bill: S.6399 • Telemedicine Billing Preferences • Net Neutrality http://www.wsha.org/wp-content/uploads/MINUTES_WA-State-Telehealth-Collaborative-03.23.18.pdf
May 7, 2018	Davis Wright Tremaine LLP Seattle, WA	• Update from ATA Meeting • WA State Payment Parity Bill • Payment Parity and Cost Savings in Telemedicine • Guidance Report http://wsha.wpengine.com/policy-advocacy/issues/telemedicine/washington-state-telemedicine-collaborative/meetings-and-minutes/
June 27, 2018	Premera Blue Cross Mountlake Terrace, WA	• Resources available from OCHIN • Telemedicine Parity, • Telemedicine Parity, Current vs. Future State • Telemedicine Parity, CPT codes • Telemedicine Parity, All Claims Database http://www.wsha.org/wp-content/uploads/MINUTES_WA-State-Telehealth-Collaborative-06.27.18.docx
August 30, 2018	Gonzaga University Spokane, WA	• Telehealth Training • Telehealth Parity, Psychiatry Perspective • Telehealth Parity, Roadmap • Telehealth Parity, Pilot Program http://www.wsha.org/wp-content/uploads/Updated_MINUTES_WA-State-Telehealth-Collaborative-08.30.18-002.docx
September 17, 2018	Virtual Meeting	• Payment Parity Workgroup http://www.wsha.org/wp-content/uploads/Updated-PP-MINUTES_WA-State-Telehealth-Collaborative-09.17.18.docx

October 19, 2018	Washington State Capitol Building Olympia, WA	• Telehealth Training • Telehealth Payment Parity (all) • Store and Forward (Sarah Orth) http://www.wsha.org/wp-content/uploads/10-19-18-Meeting-Minutes-of-the-Telehealth-Collaborative_Final.docx
November 27, 2018	University of Washington Medical Center Seattle, WA	• Follow up on Telehealth Training • Proxy Credentialing • Advice on Telehealth Technical Assistance Center • Discuss Proposed 2019 Collaborative Schedule http://wsha.wpengine.com/policy-advocacy/issues/telemedicine/washington-state-telemedicine-collaborative/meetings-and-minutes/

Website

A unique website hosting the Washington State Telehealth Collaborative was established in 2016 and has all of the meeting minutes and video recordings in 2017 and 2018. Additional resources such as best practices and frequently asked questions are available at this website. The website can be found at http://www.wsha.org/policy-advocacy/issues/telemedicine/washington-state-telemedicine-collaborative/

Provider Training

House Bill SSC 6399 required the Collaborative to include in its recommendations the design of a training program to teach health care professionals about telemedicine and proper billing methodologies. On the topic of training, members reported that many of the large health systems have standardized training programs in place unique to their health system and technologies used but there is no widely available, low-cost training available for smaller practices or solo clinicians. To ensure health care professionals delivering services through telemedicine in Washington have access to telemedicine policies and training, members of the collaborative have established a set of PowerPoint slides that can help these providers. It covers topics such as billing and coding, patient consent, malpractice, webside etiquette, documentation, and privacy issues. We are currently discussing the best ways to disseminate this information and whether it can be offered for continuing medical education credit. We will also create trainings for other types of clinicians such as nurse practitioners, physical therapists and physician assistants. There is also a set of accreditations standards set forth by the American Telemedicine Association available on their website: https://thesource.americantelemed.org/blogs/jessica-washington/2017/05/04/ata-accredits-new-teleheath-training-program

The goal in provider training is to ensure the same standard of care when delivered by telemedicine as in person. Additionally, adequate training can help prevent medical malpractice, fraud and privacy violations. The collaborative desired to inspire confidence in patients that the clinicians providing care are qualified. The collaborative agreed a telemedicine training legislative requirement would be burdensome to offering services through telehealth, costly to health systems, and difficult to monitor and reinforce. The collaborative decided the training should be voluntary. The American Telemedicine Association noted no state currently has a telemedicine provider training legislative mandate and this would be the first of its kind in the country. It was also discussed that requiring a training before offering telemedicine services could be an additional barrier to expanding telemedicine in Washington.

Cost-Effectiveness

On the topic of cost-effectiveness, the collaborative heard from Dr. Cynthia LeRouge, a professor and researcher at UW's school of public health. She made several points in her presentation. First, data collection on cost-effectiveness can be quite difficult and one's perspective on the analysis matters. For example, a particular type of telehealth program may be cost-effective from a societal perspective, but not from a health system perspective. Second, there is quite a diversity of opinion on the question of whether telemedicine is cost-effective. The answer is really, "it depends."

Data collection in this area is a challenge. The collaborative heard from Thea Mounts (Office of Financial Management, Washington State) about the All-Claims Payer database. The database was created in 2015 with the purpose to assist patients to make better choices and to promote cost and quality in the state. The data sources include Health Care Authority, health and dental plans, prescription drug claims, and labor and industries. Self-funded plans have option to submit but are not required. Oregon Health Sciences University is the contracted entity doing analyses. Funding for analyses is not provided and the collaborative would need to request funds for this activity as a class E entity.

There are also billing gaps with Medicaid and Medicare eligible locations and providers. The perceived value of telehealth is the lower cost; however, we need to know how much of a lower cost it is.

Even though telehealth services are available to patients we are finding that these services just aren't being utilized. The collaborative noticed that this is an engagement issue. If providers let patients know these services are available to them along with other engagement approaches, it could cut down on emergency room visits and help catch health issues earlier on, therefore reducing the need for more expensive care.

Payment Parity

The idea of payment parity is that a clinician should be paid the same for a telemedicine visit and an in-person visit. Payment parity laws ensure health plans do not pay for telehealth services at only a percentage of what they pay for in-person services. When clinical services delivered through telehealth are not reimbursed or reimbursed at lower rates than in-person services, the incentives to provide telehealth services decrease. Currently, there is no uniform legal approach to telehealth payment parity. In Washington, There have been two bills proposed over the last two years to this effect but they were not advanced. Instead, a pilot parity program was proposed.

The first question that the collaborative tackled was what do we mean by payment parity? To answer this, we learned that payment for health care services includes three different components: 1) professional services, 2) medical malpractice, and 3) practice expense. The practice expense covers a lot of the overhead associate with a bricks and mortar practice such as an exam table, medical assistants, and otoscopes. Several of the collaborative members believe that that aspect of the payment, the practice expense, should reflect the potential for lower overhead and practice expenses; This difference in expenses is accounted for in Medicare's reimbursement methodology. For example, a standard 15 minute follow-up doctor visit, which is typically billed as a 99213, billed in a doctor's office would result in 2.06 relative value units (RVUs). However, with a telehealth place of service, there is a lower practice expense resulting in 1.44 RVUs. This is usually a $50-60 difference. Are we talking about total reimbursement parity or an RVU conversion factor parity pilot? Members of the collaborative disagreed on this issue, with the counter argument being that overhead costs still exist but are different. For example, there can be significant initial set-up costs for software and hardware, combined with additional needs for IT support. It was noted that there have been incentives at the Federal level for many years (Meaningful Use, etc.) which were intended to address this issue. Additionally, there are many areas in medicine where ongoing technical investments are needed in order to provide the best possible care, and there are not policies or laws which require reimbursement standards to be reflective of these costs. The collaborative noted other state legislation concerning telemedicine payment parity does not define the level of detail of legislatively stipulating the RVUs for reimbursement, this is generally handled through payer policies.

The second question that was asked is whether telemedicine is clinically equivalent to an in-person visit. The sentiment was that the physical exam is often not done or it is less accurate when done by telemedicine and therefore a less complete exam should not be paid the same as in person visit. The clinicians on the collaborative responded that the physical exam is rarely informative but is often done for billing purposes. Moreover, a reliable physical exam can be performed through a telepresenter or through the use of peripheral devices, like an eStethoscope or wired otoscope. Finally, many health systems and clinicians on the collaborative who have performed telemedicine visits said that they often use them for follow-up of known patients, to discuss test results and possible treatment plans. The issue remains, however, that current reimbursement standards are based in part on the complexity and scope of physical examination, and aligning those national standards with a global parity requirement is a challenge.

The final major point of disagreement was the role of telemedicine in terms of affordability. Some in the collaborative viewed it as a way to both increase access and drive down costs. Because there is data suggesting that overall utilization of care increases with telehealth, affordability is most reliably achieved with a lower cost per telehealth visit. Others agreed with the emphasis on access but disagreed that affordability should be driven by lower unit reimbursement. They stated that earlier diagnosis and treatment is much more cost-saving in the long run than the relatively small amount saved on reduced payment to clinicians. The collaborative heard from Dr. Jurgen Unutzer, chair of Psychiatry at the University of Washington, on this topic. He related some of the challenges in working with rural clinics, such as credentialing every provider for every clinic, getting EMR access to each of the different systems, certifying provider panels for all of the insurers that the rural clinics are seeing patients and restrictions on payment from Medicaid and Medicare. Behavioral health reimbursement rates for Medicaid and Medicare are so low, about 50% of psychiatrists practicing in WA do not contract with ANY kind of insurance (Medicaid, Medicare or commercial). The majority are cash only practices, further compounding the access problem for mental health care. For these reasons, Dr. Unutzer said that UW psychiatrists would not accept any contract with less than full payment parity. In contrast, the collaborative also heard from the experience in Kaiser Permanente. Although not an RVU or volume based system, telehealth encounters in Kaiser Permanente are expected to occur with less provider time as compared to face to face visits. Despite this increase in volume expectations with no change in salary, Kaiser Permanente physicians have generally embraced telehealth because of the recognized value for patients, the variability and cognitive challenges it presents, and non-reimbursement workload benefits such as being able to work from home, etc.

Members provided language from the 4 states that have passed payment parity (KY, DE, HI and MN). However, many of these bills did not go into the depth of clarifying what is meant by parity. The collaborative reached out to many of these states to inquire if they had discussions similar to ours and how the implementation of the payment parity was going. None of the other states we reached out to discussed RVU components of reimbursement as part of telemedicine payment parity. Additionally, we were not able to obtain any data on whether payment parity resulted in an increase in reimbursement costs to payers; payers noted the implementation was too soon/short to discern.

The collaborative also discussed that payment parity is inherently limited as parity implies equal to something that already exists. Store and forward services and remote patient monitoring services are not likely to be included in state telemedicine payment parity laws, the laws are usually restricted to real-time audio video services.

Senator Becker has drafted a Washington State Payment Parity Bill; *S.6399* (see Appendix 1). This bill was passed with the understanding that the collaborative would have a deep dive discussion on payment parity and to develop recommendations for a pilot. One thing that was noticed is even in the states that do have payment parity, the rules behind it were inconsistent. Our priorities, in this area, over the last 6 months of the year were:

- Know what the CPT codes are and diagnosis that pairs with it.
- Create a bill where we work with carriers ahead of time. This will eliminate unintended language and allow us to strategize if everything should be in one bill, or multiple bills.
- Does parity exist? Identify a standard of care.
- Convince small hospitals that the credentialing process is positive. Create a practice for credentialing.
- Timeline for this work.

Senator Becker created a new bill on payment parity. The collaborative reviewed this bill on October 19, 2018 and provided feedback. It is on track to be submitted December 1, 2018.

The collaborative also discussed existing language Washington law, Title 182, Chapter 182-531 Section 1730[1] related to reimbursement of clinical services delivered through store and forward modalities. Store and forward is the collection of clinical information and transmitting it electronically to another site for evaluation. In order to be reimbursed for clinical services delivered through the store and forward (S&F) telehealth modality, per Washington law there must be an associated office visit between

[1]Available online at: http://apps.leg.wa.gov/wac/default.aspx?cite=182-531-1730

the client and the referring health care provider. The requirements for an associated office visit between the client and the referring health care provider is restrictive and inhibits clinicians offering store and forward services in Washington. The requirement for an associated office visit between the client and referring health care provider for the evaluating clinician to be reimbursed creates a requirement for an additional health care encounter as compared to an equivalent in-person service. Additionally, this language eliminates reimbursement for store and forward services for patients that do not have a referring health care provider. Some patients do not have a referring provider to conduct this associated office visit with. These same services when delivered in-person do not require an associated office visit between the client and the referring health care provider for reimbursement.

Additionally, amongst collaborative members health system compliance departments are interpreting this requirement for an associated office visit differently, resulting in variation of service delivery. The language in the law is confusing and preventing reimbursement for store and forward services. If this language were struck from the law, it would enable additional services for patients and increased access to care, less complicated reimbursement requirements for store and forward services, align reimbursement requirements for the same services delivered by other modalities, and align Washington store and forward reimbursement law with federal direction. CMS created specific coding for "the remote professional evaluation of patient-transmitted information conducted via pre-recorded 'store and forward' video or image technology" which does not require an associated office visit with the referring provider. The following modification to the law is recommended:

Telemedicine is when a health care practitioner uses HIPAA-compliant, interactive, real-time audio and video telecommunications (including web-based applications) or store and forward technology to deliver covered services that are within his or her scope of practice to a client at a site other than the site where the provider is located

Appendix 1:

HOUSE BILL REPORT
SSB 6399

As Passed House:
February 27, 2018

Title: An act relating to telemedicine payment parity.

Brief Description: Concerning telemedicine payment parity.

Sponsors: Senate Committee on Health & Long Term Care (originally sponsored by Senators Becker, Cleveland, Rivers, Brown, Bailey, Fain, Kuderer and Van De Wege).

Brief History:
Committee Activity:
Health Care & Wellness: 2/20/18, 2/21/18 [DP].
Floor Activity:
Passed House: 2/27/18, 98-0.

Brief Summary of Substitute Bill

- Requires the Collaborative for the Advancement of Telemedicine to review the concept of telemedicine payment parity, develop recommendations including parameters for a payment parity pilot program, and report to the Legislature by December 1, 2018.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

Majority Report: Do pass. Signed by 17 members: Representatives Cody, Chair; Macri, Vice Chair; Schmick, Ranking Minority Member; Graves, Assistant Ranking Minority Member; Caldier, Clibborn, DeBolt, Harris, Jinkins, MacEwen, Maycumber, Riccelli, Robinson, Rodne, Slatter, Stonier and Tharinger.

Staff: Kim Weidenaar (786-7120).

Background:

<u>Telemedicine and Store and Forward Technology</u>.
Telemedicine is the use of interactive audio, video, or electronic media for the purpose of diagnosis, consultation, or treatment of a patient at an originating site. Store and forward

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This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

technology is the use of an asynchronous transmission of a patient's medical information from an originating site to a provider at a distant site.

A health plan offered by a health carrier, a health plan offered to state employees and their dependents, and a Medicaid managed care plan must reimburse providers for health care services provided through telemedicine or store and forward technology if:

- the services are covered services;
- the services are medically necessary;
- the services are essential health benefits under the federal Patient Protection and Affordable Care Act;
- the services are determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards; and
- the technology meets state and federal standards governing the privacy and security of protected health information.

An originating site for telemedicine includes a hospital, rural health clinic, federally qualified health center, health care provider's office, community mental health center, skilled nursing center, renal dialysis center, a home, or any location determined by the individual receiving the services. A facility fee may not be charged for telemedicine services offered to a patient in his or her home or other location of patient's choosing. For services provided from a distant site, Health Care Authority policy requires payment for services provided through telemedicine to be the same as services provided in-person, but requires the Current Procedural Terminology code to indicate the service was provided remotely.

<u>Collaborative for the Advancement of Telemedicine</u>.
In 2016 the Collaborative for the Advancement of Telemedicine (Collaborative) was created to enhance the understanding of health services provided through telemedicine. The Collaborative is hosted by the University of Washington Telehealth Services and is comprised of one member from each of the two largest caucuses of the Senate and the House of Representatives, and representatives from the academic community, hospitals, clinics, and health care providers in primary care and specialty practices, carriers, and other interested parties.

The Collaborative is required to develop recommendations on improving reimbursement and access to services, including reviewing the originating site restrictions or additions proposed in this bill, provider-to-provider consultative models, and technologies and models of care not currently reimbursed. The Collaborative must identify telemedicine best practices, guidelines, billing requirements, and fraud prevention developed by recognized medical and telemedicine organizations. The Collaborative must also make a recommendation on whether to create a technical assistance center in Washington to support providers in implementing or expanding services delivered through telemedicine. An initial progress report was due December 1, 2016, with follow-up reports due December 1, 2017, and December 1, 2018. Reports must be shared with the Health Care Committees of the Legislature as well as relevant professional associations, governing boards, or commissions. Meetings must be open public meetings with summaries available on a web page.

The future of the Collaborative shall be reviewed by the Legislature with consideration of on-going technical assistance needs. The Collaborative terminates December 31, 2018.

Summary of Bill:

The Collaborative for the Advancement of Telemedicine (Collaborative) must review the concept of telemedicine payment parity and develop recommendations on reimbursing for telemedicine at the same rate as if a provider provided services in person for treatment of diabetes mellitus, stroke, mental health conditions, opioid dependence, and chronic pain.

In developing its recommendations, the collaborative should include a review of various reimbursement methodologies, and must consider whether and the extent to which facility fees should be reimbursed in providing telemedicine services.

The recommendations must include parameters for a three to five year telemedicine payment parity pilot program (TPPPP), which uses a recommended payment parity and facility fee reimbursement methodology for reimbursing services utilized to treat the five conditions listed above. The TPPPP parameters must outline procedures for the Collaborative and the Office of Financial Management to analyze claims data in the all-payer health care claims database to determine if any savings or increased telemedicine or store and forward utilization are realized through the TPPPP. Finally the Collaborative's recommendations must include the design of a training program to teach health care professionals about telemedicine and proper billing methodologies.

By December 1, 2018, the collaborative must report its recommendations for the TPPPP to the health care committees of the Legislature.

Appropriation: None.

Fiscal Note: Available.

Effective Date: The bill takes effect 90 days after adjournment of the session in which the bill is passed.

Staff Summary of Public Testimony:

(In support) The original goal for this bill was to create a payment parity program, but several issues arose and it became apparent that it was going to take longer than just this session to come to an agreement. Accordingly, the Collaborative for the Advancement of Telemedicine (Collaborative) was tasked with creating the pilot program. Another task placed on the Collaborative is to develop education for providers about telemedicine, reimbursement, and fraud issues. Only two states, Hawaii and Minnesota, have telemedicine payment parity models. The Collaborative will take a comprehensive look at these models and report back to the Legislature as required by the bill. Payment parity for telemedicine is an issue that has a lot of varying opinions across providers, as well as carriers. Given the varying opinions on payment parity, this will be a difficult task for the Collaborative to develop recommendations, but the recommendations are limited to only five conditions. Supporters are excited for the pilot to start to see if it accomplishes its goals and will save patients and carriers money.

(Opposed) None.

Persons Testifying: Senator Becker, prime sponsor; and Ian Goodhew, University of Washington School of Medicine.

Persons Signed In To Testify But Not Testifying: None.