WashingtonState
TelehealthCollaborative

Meeting Minutes

August 30, 2018
11:00am-1:00pm
Hemmingson Center, Rm 314B
Gonzaga University, Spokane, WA

Attendees (In Person): John Scott (UW), Senator Randi Becker, Representative Marcus Riccelli, Representative Joe Schmick, Dr. Jeff Jones (Newport Family Medicine), John Bose (Labor & Industries),

Attendees (By Phone): Brodie Dychinco (Cambia Health Solutions/Regence Blue Shield), Joshua Frank (ACEM), Kathleen Daman (Swedish), Sarah Orth (Seattle Children's), Chris Cable (Kaiser), Sheryl Huchala (Premera Blue Cross), Cara Towle (UW Dept of Psychiatry), Frances Gough (Molina), Joelle Fathi (WSNA), Adam Romney, Chad Gabelein (Virginia Mason)

Members of public: Lisa Roche (Providence), Marissa Ingalls, Michelle Martinez, Katie Kolan (WSMA), Stafford Strong (Senate Republican Caucus), Tracy Drake,

Meeting convened at 11:05am

I. **Review of 05.07.18 Meeting Minutes**
   - **a.** Minutes reviewed
   - **b.** Rep Schmick motioned for approval, Sen Becker seconded approval
   - **c.** Motion passed unanimously to approve meeting minutes
   - **d.** **ACTION**: June meeting minutes to be posted on Telehealth Collaborative Website

II. **Telehealth Training (John Scott, comments prepared by Denny Lordan)**
   - a. Reference: comment document in meeting packet, which summarizes comments mostly from providers groups including physicians and hospitals
   - b. American Telemedicine Associated (ATA): Unusual to have a training requirement; no other state has this requirement. ATA expressed a concern for adding an additional barrier.
   - c. Sarah Orth: suggestion for online curriculum

d. Sen Becker: intent of the legislation is not to have providers train in person. Since telemedicine is not part of medical school or nursing school curriculum, goal is to have MDs, DOs, specialists train through a format like Project ECHO. Concern with training is more so for non-physician providers. Thought process around certification is geared toward allied health professionals to ensure competency is there.
e. Dr. Scott: UW Medicine requires "privileging" for telehealth. Includes a 1-hr online Learning Management System (LMS) training.
f. Kathleen: Swedish uses a similar system with online training and a live hands on training.
g. Chad Gabelein: videos with assessment used for training. Smaller organizations might struggle with augmented physician groups to ensure everyone is privileged. Important for all providers to have training, but difficult to ensure that training is uniform across all providers.
    i. Ex// Consideration for contracting with telehealth companies like Carena, which offer their own training. How do we ensure 3rd party vendors provide adequate training?
    ii. Dr. Scott: proposed to circle back with Chad, Sarah and Kathleen to draft a document of considerations and recommendations to bring to next Collaborative meeting
h. Sarah Orth: Seattle Children's has a privileging process with a live demo session. Go-live support provided at the elbow. Curriculum includes policies, procedures, documentation and is tailored to the platform being used. Collaborative could develop a generalized training, including telehealth 101, where to access clinical standards, and put this online as a module for all to access.
i. Joelle: endorsed the idea of an online module created by the Collaborative. All staff, including nurses, should have some level of telehealth training to ensure they understand security and privacy considerations of the technology.
j. Kathleen: supports the creation of basic online training that would apply to all staff and providers
k. Jeff: mandating training for support staff would be a barrier for small practices. Physicians are responsible for ensuring they are competent in the services being provided, does not need to be legislatively mandated.

l. Sen Becker: perhaps professional schools certifying MAs and other allied health would consider adding telehealth fundamentals to their curriculum
m. Rep Schmick: who would be responsible for enforcing the legislation?
    i. Rep Riccelli: online module could produce a printable certificate upon completion, similar to training now required for youth sports coaches
n. Geoff Jones: Rather than make training a requirement for licensure, could make this training a requirement for billing
    i. Kathleen: Billing changes are frequent so this approach may be challenging
o. ACTION: John, Sarah, Chad and Kathleen to draft a training PowerPoint for Collaborative members to review

III. Telehealth Parity, Psychiatry Perspective (Guest: J Unutzer)

a. Dr. Jurgen Unutzer chairs the Department of Psychiatry at UW Medicine
b. Severe behavioral health workforce shortage in WA State, telehealth is a solution to help distribute the behavioral health specialists across regions with disparate access
c. Mental health care very well suited to telehealth because do not typically need a psychical exam, and can include the local provider for a 3-way conversation
d. About half of the 39 counties in WA State have no psychiatrist or psychologist
e. Barriers and challenges in working with rural clinics: credentialing every provider for every clinic, getting EMR access to each of the different systems so that can read notes, paneling on provider panels for all of the insurers that the rural clinics are seeing patients from, research funding running out, payment barrier for Medicaid and Medicare
f. Behavioral health reimbursement rates for Medicaid and Medicare are so low, about 50% of psychiatrists practicing in WA do not ANY kind of insurance (Medicaid, Medicare or commercial). The majority are cash only practices, further compounding the access problem for mental health care.
g. Therefore, if asking psychiatrists to provide telemedicine to rural areas with high Medicare/Medicaid populations, would be a non-starter if payment was less than if the patient came for an in-person clinic visit

h. True cost of completing telehealth with rural settings is somewhat higher than a patient coming to clinic. Extra time needed to have good communication with the physical site, and start-up costs are significant.
i. UW Medicine currently billing all professional fee, no facility fee for TelePsychiatry services
j. Telehealth does not increase the total volume of visits across the state, but does create more equitable distribution of visits to rural areas that otherwise would have a very low chance of seeing a mental health provider.
k. Parallel benefit: significant learnings and education for the rural providers
l. Alternative model (Behavioral Health Integration Program): review of a case load of patients, billed using collaborative care billing codes. This model does increase overall number of patients reviewed—only those who really need to be seen have a televisit with a behavioral health provider
m. Most of the work being done at UW Medicine is supported by federal grants and/or direct contracts with MCOs. Very little business being billed as FFS revenue; would be difficult to keep a practice solvent on a FFS model.

IV. Telehealth Parity, Roadmap (Sen. Becker)

a. Need to have a document to legislature by Dec. 1 which outlines the nuts and bolts of a parity pilot
b. Pre-filing the bill would mean dropping it the first week of December, which would make it public. Allows the legislature to start working the bill early and improves outlook for the legislative session.
c. Minor tweaks to the bill from last year would be 1-2 weeks for staff to complete
d. Sen. Becker recommends writing a new bill, which would be a longer development process but offers more opportunity for design of the pilot
e. Rough development timeline:
    i. Oct 8th or 13th: concept language would need to be to staff
        1. Staff would have 3-4 weeks to provide a first draft of the bill
    ii. Nov 13th: First draft ready to review, at which point it should be distributed to all Collaborative members for feedback.
    iii. Nov 22nd: comments need to be provided to staff

iv. Final bill from Code Revisor Office
v. 1st week of December: Sponsor gathers signatures and submits

f. ACTION: Telehealth Collaborative to produce policy language in the next 6 weeks

g. ACTION: Change language for pilot inclusion to diabetes, stroke and mental health/substance use disorders (vs. psychology)

V. Telehealth Parity, Pilot Program (All)

a. Background provided by Brodie: No facility bill charged with telehealth, all professional fees. For parity there may still be a difference in payment because of facility fee. Goal was to determine that cost will not go up as a result of reimbursement parity, how do we know we have accomplished that?

b. 3 ways billing occurring today: consult code, E&M code, 99441-99444 codes

c. Regence uses same conversion factor for reimbursement. Does not believe Molina has that same process. Premera does not require use of 99441-99444 codes, they also allow the use of a regular E&M code with a GQ modifier.

d. Molina also allows the use of E&M with a GQ modifier. L+I uses E&M with a GQ modifier.

e. Senator Becker: should be able to use office visit codes, consider consult codes to be a down-code from the service that is actually being provided. Difference between a 9944x code and E&M example is ~$23 vs. ~$74

f. KP: video visit is coded with E&M with a GQ modifier, they are moving eConsults to 99446-9 codes

g. Group consensus that eConsults should use 9944x codes and that eConsults would not fall under the parity pilot since the service is significantly different

h. Dr. Scott: Parity should be measured in RVUs at Medicare rates.

i. Note that Medicare does pay an originating site fee, Q3014 with maximum fee of $26

j. Kathleen Daman: for Swedish charging only the pro fee would be acceptable

k. Sarah Orth: Seattle Children's already receiving parity level payments for video visits, so participation in pilot as scoped would not add value. Expressed interest in store and forward.

l. Recommend to reach out to Sue Birch regarding potential risk for cost shifting.
m. Dr. Gough: have struggled to provide services at current Medicaid rates, running a pilot may help in the short term, but does not create a long-term sustainable model. VBP environments make it easier to build out telehealth.
n. Brodie: several provider groups have public facing services as low as $35, how does this square with requirement to charge all (plans and patients) the same?
o. **ACTION: Sen. Becker to reach out to Sue Birch regarding Medicaid rates**
p. **ACTION: Cara Towle to follow up with Jurgen to understand which specific rates are of concern**
q. **ACTION: Dr. Scott to send Kentucky policy language to Collaborative members**

VI. Public Comment Period

a. Rep Riccelli: seeking feedback on nursing compact. Medical Licensure compact has been beneficial for MDs and DOs, could provide similar benefits for nurses.
    a. Rep Schmick: Support of concept but challenge has been the background checks and qualifications required
b. Katie Kolan requested to review the parity proposal and share feedback

Meeting adjourned 12:59pm

Next meeting: Oct 19th, 2-4 pm, Olympia, WA at Senate Caucus Room State Capitol Bldg