

Payment Parity Workgroup Meeting Minutes

Sept 17, 2018

Phone and Zoom Call

Attendees: John Scott (UW), Chad Gablein (Virginia Mason), Brodie Dychinco (Cambia Health Solutions/Regence), Sheryl Huchala (Premera Blue Cross), Sarah Orth (Seattle Children's), Chris Cable (Kaiser), Kathleen Daman (Swedish), Sen. Randi Becker, Joelle Fathi (WA State Nursing Assn)

Members of public: Lisa Roche (Providence), Stafford Strong (WA State Republican Caucus)

The meeting began at 11:00 with introductions.

Sarah Orth started by sharing slides about what other states have considered or passed with regards to payment parity.

1. Kentucky. Kentucky Governor Matt Bevin signed SB 112 into law on April 26, 2018, which mandated both telehealth coverage and payment parity requirements for Kentucky Medicaid, Medicaid managed care organizations, and commercial health plans. The law goes into effect Jan 1, 2019. The specific key language is below:

““A health benefit plan shall reimburse for covered services provided to an insured person through telehealth as defined in Section 4 of this Act. Telehealth coverage and reimbursement shall be equivalent to the coverage for the same service provided in person unless the telehealth provider and the health benefit plan contractually agree to a lower reimbursement rate for telehealth services.”

2. Minnesota. Private payers are required to provide coverage for telemedicine in the same manner, and at the same reimbursement rate, as other services provided in person. This applies to plans that begin on or after Jan. 1, 2017.

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A health carrier can establish criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a service via telemedicine. They can also require a health care provider to agree to certain documentation or billing practices to protect against fraud.

Source: MN Senate File 1458 (2015). MN Statute Sec. 62A.672.

3. Delaware. Private payers must provide coverage for the cost of health care services provided through telemedicine, and telehealth as directed through regulations by the Department.

Insurers must pay for telemedicine services at the same rate as in-person.

Source: Title 18, Sec. 3370; & Title 18, Sec. 3571R.

4. Hawaii. Hawaii requires coverage of telehealth services, equivalent to reimbursement for the same services provided via-face-to-face contact.

Source: HI Revised Statutes § 432D-23.5.

Sarah has consulted with an health care attorney who works with the Center for Telehealth and e-Health Law (CTeL), Nate Lacktman at Foley & Gardner LLP, and he had suggested the following language for consideration:

"For purposes of reimbursement and payment, a health plan shall compensate the health care provider for covered services provided through telemedicine on the same basis and the same payment rate the health plan would apply to the services if the services had been delivered in-person by the health care provider. Nothing in this section is intended to prohibit a health plan and a health care provider from voluntarily agreeing to alternate rates, including risk-based or other value-based payment methodologies, for health care services provided through telemedicine."

The last sentence in this language in particular allowed for national telemedicine companies who may have a different cost structure and use cases to charge a different fee.

In writing proposed legislation, Sarah Orth made the following clarifications:

- Payment parity laws do not require a health plan to pay a telemedicine-only company (e.g., XYZ Care) in the same manner or the same rate that health plan pays a different provider (e.g. a traditional hospital, or even a different telemedicine provider).

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- The payment parity laws only require the health plan, under its specific participation agreement with any given hospital or medical group, to pay that specific entity the same rate for services delivered via telehealth that the health plan pays that specific hospital for services delivered in-person
- Payment parity laws would not require the health plan to pay all providers the same reimbursement rate.
- Interpreted otherwise, payment parity laws would eviscerate contract negotiations and impose a universal fee schedule for commercial health plans, which is clearly not the case nor the intent/purpose of these laws. The health plan is able to continue negotiating with providers on a per-provider basis, as is typical.

Brodie Dychinco then spoke. Regence has a different reimbursement policy with regards to telemedicine compared with other payers. In particular, they've recommended using the 9944x codes, instead of outpatient or inpatient consultation or visit E&M codes (99201-99215, 9923x, 9921x). The members of collaborative representing physicians and hospitals pointed out that the relative value unit (RVU) is quite a bit lower for 9944x compared with the other codes (approximately 20% lower), resulting in lower payment. Brodie inquired what would happen if Regence changed their policy to be in line with other payers, would that meet the needs of everyone in the collaborative? This question was not directly answered, as an additional complexity arose.

He said that Regence is simply following Medicare guidelines when using the place of service (POS) code 2, which is the modifier that should be used when billing Medicare for telemedicine services. Medicare breaks up the total fee into several different components, including the work of the doctor, malpractice coverage and the **practice expense**. He gave the example of a standard 15 minute follow up doctor visit, which is typically billed as a 99213. If a doctor billed this for a standard in person visit, he would be credited 2.06 RVUs. However, for a telemedicine visit, there is no practice expense (such as the cost of the room, medical assistants, etc), so that portion of the bill should be removed, resulting in a 1.44 RVU charge. He expressed his concern that it's unprecedented to legislate what RVU's to use and how much providers should be paid. It opens the door to a lot of downstream impacts to start that precedence.

Brodie's last point was about the purpose of the payment parity pilot. If it's a pilot, then it means that we need to learn/confirm something to know whether it should

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continue beyond the pilot. He encouraged the collaborative to figure out what we can measure with confidence without over-complicating it, so we know whether the pilot can be concluded. If we don't learn/confirm/measure/assess, then we shouldn't call it a pilot and we should frame it as a permanent change.

In response, clinician and hospital groups (Scott, Fathi, Gablein, Daman) said that there are other costs associated with telemedicine visits that should be considered as practice expenses. These include the cost of the technology (both software and hardware), technician time and patient care coordinators who assist patients in using telemedicine technology. Furthermore, telemedicine visits can take longer and clinicians are not able to run multiple rooms like they can in person, resulting in reduced efficiency.

Chris Cable then spoke. He clarified that Kaiser Permanente would not be interested in total reimbursement parity, but rather RVU conversion factor parity. The total reimbursement to a clinician or hospital is based on formula:

Total payment = conversion factor x RVU (based on CPT code)

The conversion factor is negotiated between the payer and clinical entity and varies. Chris' position was supported by other payer group representatives on the call.

In summary, there was not agreement that overhead costs with telemedicine are lower compared with an in-person visit. Even using total reimbursement parity for a limited set of conditions for the pilot was not agreed upon by all parties. There still needs to be a conversation about recommendations about which CPT codes to be used (9944x vs. other codes).

Meeting adjourned 12:04pm