HOW TO INFLUENCE

STATE POLICY

August 29, 2019

AGENDA

ROADMAP

What is
What could be
How do we get there?
2019 Washington legislative activity

STEP 1: KNOW THE LANDSCAPE

WHAT IS

UNDERSTAND CURRENT STATE OF TELEHEALTH POLICY

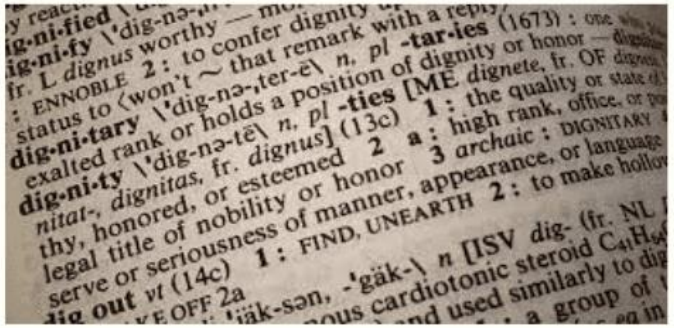
WASHINGTON STATE TELEHEALTH COLLABORATIVE

VISION

The Collaborative will advance excellence and innovation in telehealth for all Washington communities, improving access to high-quality, safe and affordable health care in Washington State

MEMBERS

Dr. John Scott, Director of Telehealth Services, UW Medicine, Collaborative Chair
Washington State Senator Randi Becker
Washington State Representative Marcus Riccelli
Washington State Senator Annette Cleveland
Washington State Representative Joe Schmick
Dr. Chris Cable, Senior Medical Director, Kaiser Permanente Washington
Kathleen Daman, Telehealth Clinical Program Manager, Swedish Health Services
Brodie Dychinco, General Manager of Convenient Care Delivery, Cambia Health Solutions/Regence
Joelle Fathi, DNP, RN, ANP-BC, Director of Nursing Practice and Health Policy, Washington State Nurses Association
Dr. Frances Gough, Chief Medical Officer, Molina Healthcare
Sheila Green-Shook, Chair, Advocacy Committee, Washington State health Information Management Association
Sheryl Huchala, Contracting Manager, Premera Blue Cross
Dr. Ricardo Jimenez, Vice President of Medical Affairs and Chief Medical Officer, Sea Mar Community Health Centers
Dr. Geoff Jones, Family Physician, Newport Community Hospital
Dr. Scott Kennedy, Chief Medical Officer, Olympic Medical Center
Denny Lordan, Telehealth Program Coordinator, Providence Healthcare
Adam Romney, Partner, David Wright Tremaine, LLP
Dr. John Scott, Director of Telehealth Services, Chair, UW Medicine
Cara Towle, RN MSN MA , Associate Director Integrated Care Training Program & Psychiatry Consultation Program, UW Medicine
Lori Wakashige, Program Director, Regional Outreach & Telehealth, Legacy Health
Stephanie Cowan, Clinical Care Director –Virtual Health | MultiCare Health System
Sarah Orth, Telehealth Program Manager Senior, Seattle Children's Hospital



DEFINITIONS

Clinical Services
Technology

Clinical Services

PROVIDER TYPES

Some states have limitations around the provider types that can be reimbursed by telehelath services.

LICENSING

Most states require licensure in the state the patient is located at the time of the telemedicine visit.

CREDENTIALING & PRIVILEGING

Credentialing and privileging is usually required at any health care facility, and may be allowed to be completed by proxy (acceptance of distant site decisions).

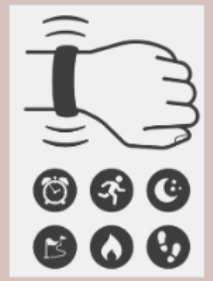
OPERATIONS

Check to see if laws, regulation, or policy exist about clinical standards of practice via telemedicine, informed consent, provider locations, prescribing, privacy for minors, etc.

TECHNOLOGY

Live audio-video

Asynchronous/
store and forward



Remote monitoring/
wearables

PARITY

COVERAGE VS. PAYMENT

Coverage: Refers to clinical services delivered through telehealth must be "covered", or cannot not be reimbursed by payers (usually third-party and/or Medicaid)

Payment: Refers to the payment of services delivered in-person or by telemedicine must be the equal.

- Six states have payment parity laws on the books: Arkansas, Colorado, Delaware, Kentucky, Minnesota, New Jersey
- Proposed 2019 telehealth payment parity legislation
  - Three state passed: Georgia, New Mexico, Mississippi
  - One state still active: California
  - Five states failed: Massachusetts, New York, North Carolina, Oregon, Washington
- Five states have laws enacted related to payment but do not require payment parity: Kansas, Louisiana, North Dakota, Tennessee, Texas
- Other states introduced bills related to telemedicine payment but not parity

STEP 2: KNOW THE IDEAL FUTURE

WHAT COULD BE

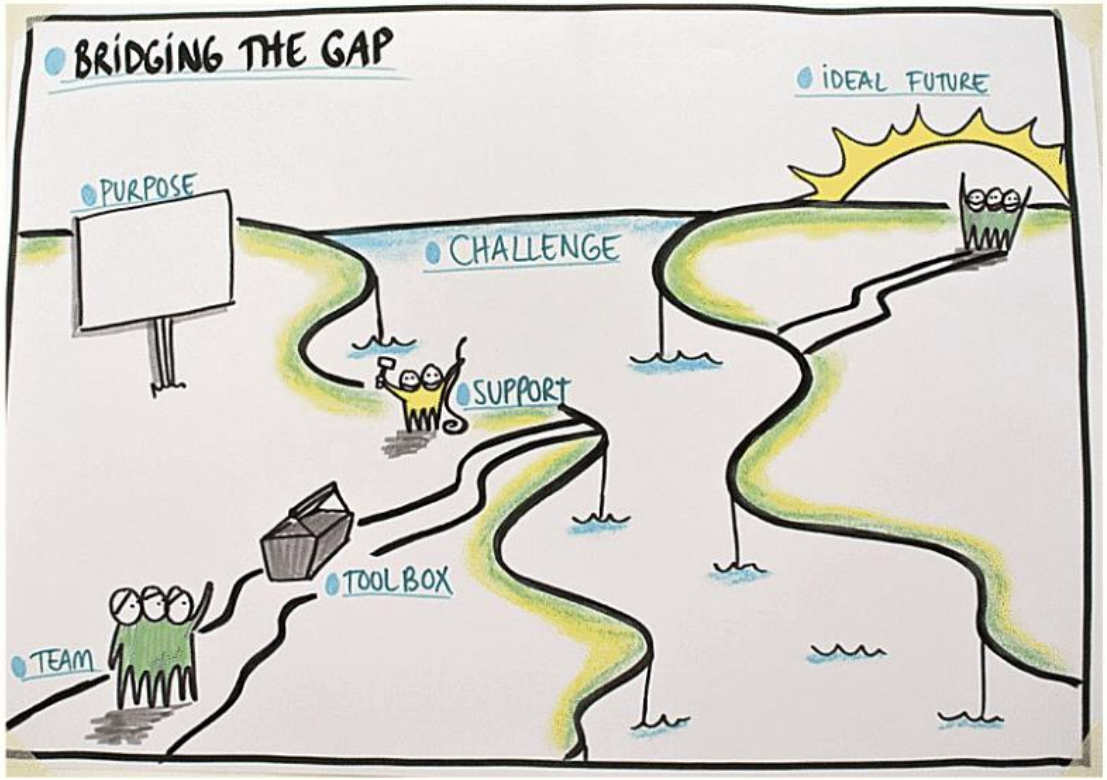
GOAL

NEVER HEAR THE WORD "TELEHEALTH" AGAIN

Offering services in person or virtually in any modality = no difference in operational process, clinical care quality or patient safety

STEP 3: GAPS

HOW DO WE GET TO IDEAL FUTURE?



WHAT TO DO?

CLOSE THE GAPS AND DIG IN

- Find legislator champions and be their friend
- Propose reasonable steps to close the gap, it won't be perfect the first time
- Find stakeholder champions and identify what they are willing to do/change
- Stay in the limelight
- Balance what could be with current environment; don't make it too radical or restrictive
- Take advantage of existing stakeholder advocacy groups whenever possible

Washington State Telehealth Collaborative

2019 WASHINGTON TELEHEALTH LEGISLATION

DISCUSSED, PROPOSED, LEGISLATIVE OUTCOME

SENATE BILL 5387: CREDENTIALING BY PROXY

DISCUSSION

Washington had an existing law that enabled telemedicine privileging by proxy.
This proposal added to the existing law the possibility for telemedicine credentialing by proxy.
When granting or renewing credentials of any physician providing telemedicine services, an originating site hospital may rely on a distant site hospital's decision to grant or renew credentials.

PROPOSED LEGISLATION

Modified existing legislation to add "credentialing and" to each instancing of telemedicine privliging by proxy

OUTCOME

Passed, no modifications

Signed by Governor

Effective 7/28/19

https://app.leg.wa.gov/billsummary?BillNumber=5387&Initiative=false&Year=2019

SENATE BILL 5386: TELEMEDICINE TRAINING

DISCUSSION

Concerns for rural and independent health care professionals about following standards of care and knowing all of the rules for delivering care via telemedicine. It was decided the Washington State Telehealth Collaborative

PROPOSED LEGISLATION

Beginning January 1, 2020, health care professionals who provide services through telemedicine shall complete telemedicine training prior to providing those services. The training may be incorporated into existing telemedicine training.

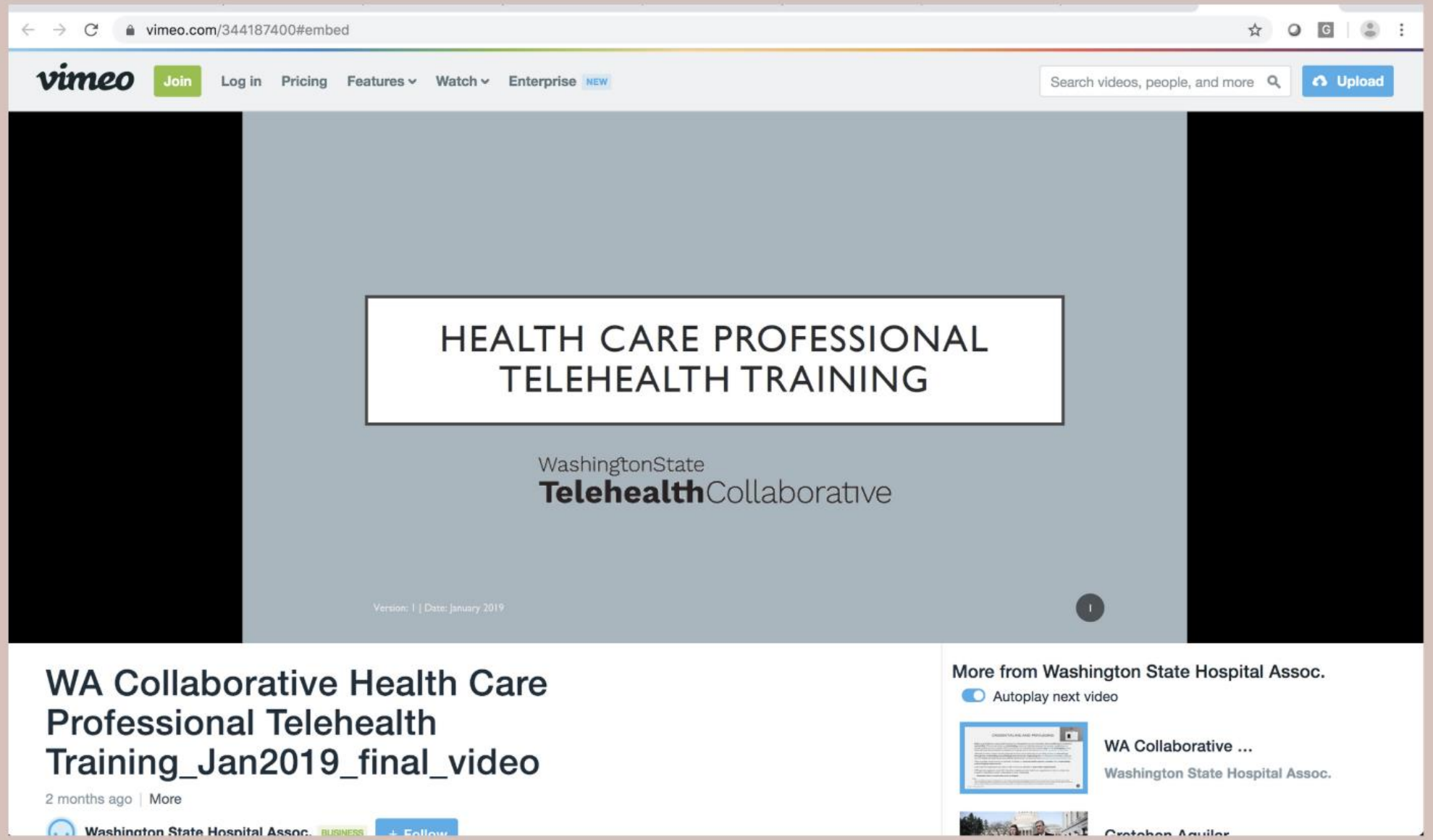
OUTCOME

Passed, with modifications training optional/"may"

Signed by Governor

Effective 7/28/19

https://app.leg.wa.gov/billsummary?BillNumber=5386&Initiative=false&Year=2019



https://vimeo.com/344187400

SENATE BILL 5385: TELEMEDICINE PAYMENT PARITY

DISCUSSION

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. 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

PROPOSED LEGISLATION

Added language to existing coverage bill for real time audio-video payment parity: at the same rate as if the health care service was provided in person by the provider

Removed requirement for an associated office visit with referring provider for store and forward reimbursement

OUTCOME

Died

https://app.leg.wa.gov/billsummary?BillNumber=5385&Initiative=false&Year=2019

THINGS TO KEEP IN MIND

SURVIVAL TIPS FOR INFLUENCING POLICY

Always think far ahead.

Changing policy is a hard, long journey. Make small policy changes incrementally towards your end goal over time. Revisit and re-engage stakeholders to evaluate previous years' policy changes and propose more changes.

Do contingency planning.

Have a plan for compromise or bill failure. What can you do to improve the vetting process next year?

Strategically engage stakeholders.

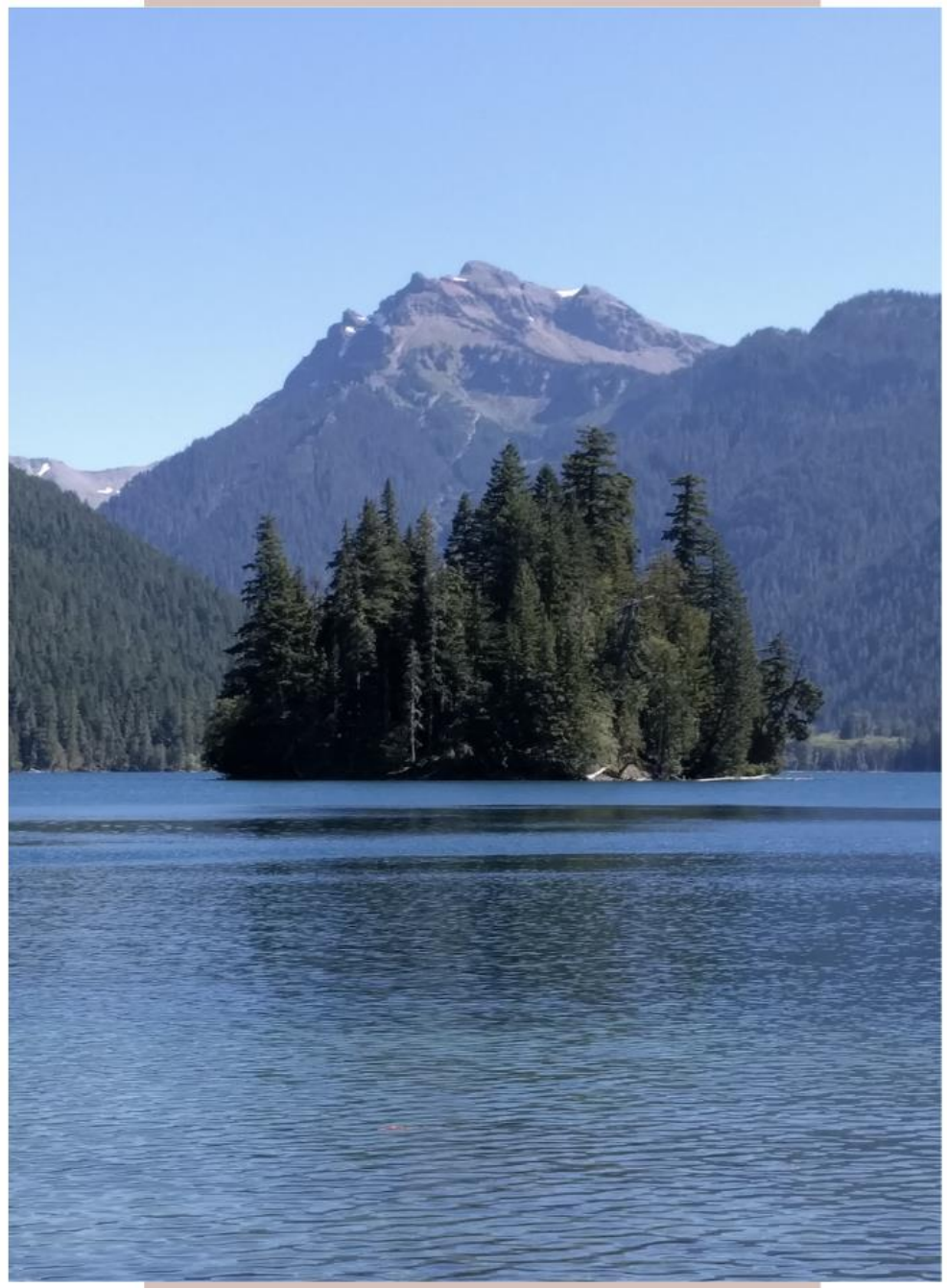
Find the active movers and shakers and be their friend. Find the "win" from each perspective and build it into the draft bill language. Fully address opposition before dropping the bill

SARAH ORTH
SEATTLE CHILDREN'S
sarah.orth@seattlechildrens.org

WASHINGTON STATE TELEHEALTH COLLABORATIVE

NICOLE LAGRONE
nlagrone@uw.edu

FOR QUESTIONS AND CLARIFICATIONS



TELEHEALTH POLICIES: Federal & State

NORTHWEST REGIONAL TELEHEALTH RESOURCE CENTER CONFERENCE

August 30, 2019

877-707-7172
cchpca.org

CENTER FOR CONNECTED HEALTH POLICY

Mei Wa Kwong, JD
Executive Director, CCHP

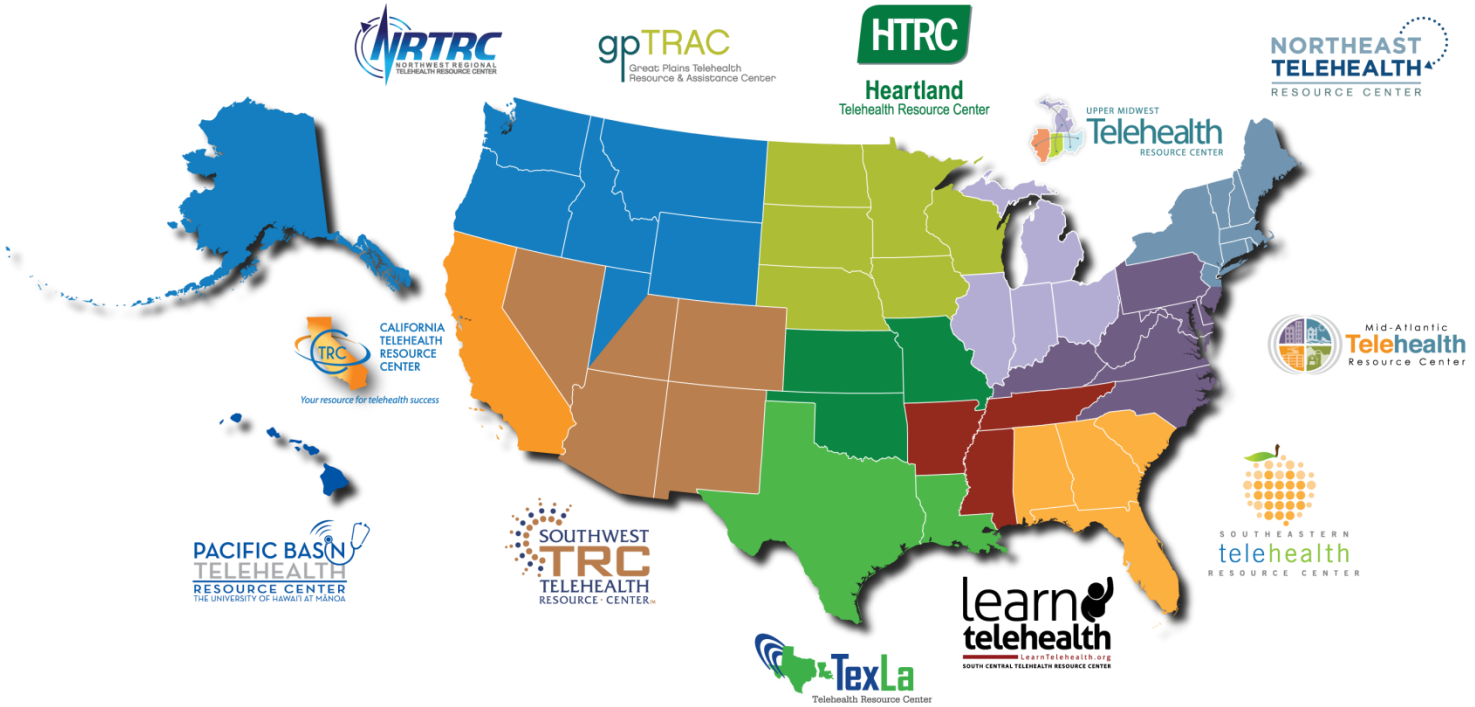
DISCLAIMERS

- Any information provided in today's talk is not to be regarded as legal advice. Today's talk is purely for informational purposes.
- Always consult with legal counsel.
- CCHP has no relevant financial interest, arrangement, or affiliation with any organizations related to commercial products or services discussed in this program.

Center for Connected Health Policy
The National Telehealth Policy Resource Center

CCHP is an independent, ***public interest*** organization that strives to advance state and national telehealth policies that promote better systems of care improved health outcomes and provide greater ***health equity of access to quality, affordable care and services.*** CCHP is a program under the Public Health Institute.

TelehealthResourceCenter.org



TTAC TelehealthTechnology.org
National Telehealth Technology Assessment Resource Center

Center for Connected Health Policy
The National Telehealth Policy Resource Center

2 National Resource Centers

NRTRC	gpTRAC	NETRC
CTRC	HTRC	UMTRC
SWTRC	SCTRC	MATRC
PBTRC	TexLa	SETRC

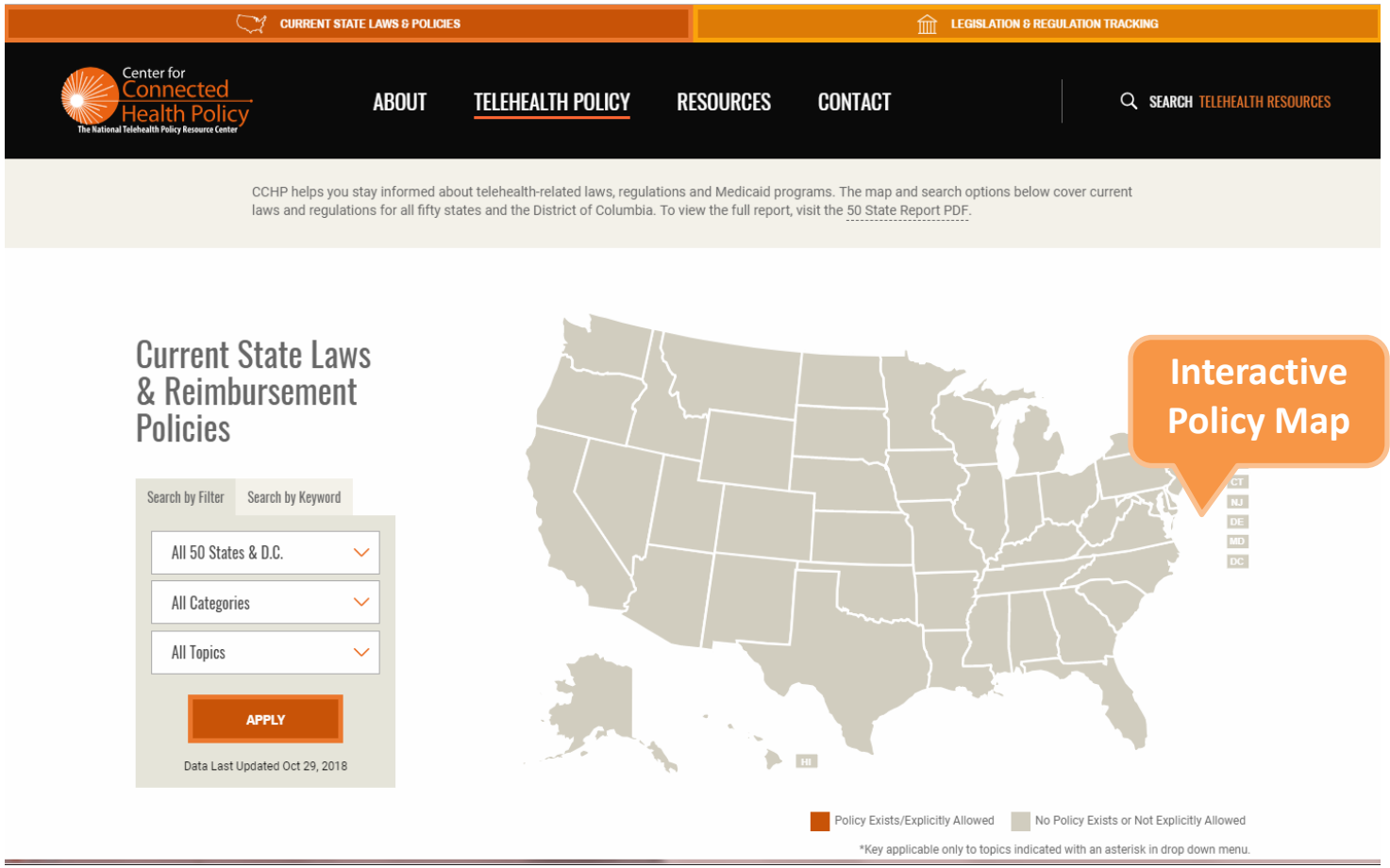
12 Regional Resource Centers

TRC

TELEHEALTH RESOURCE CENTERS

CENTER FOR CONNECTED HEALTH POLICY

TELEHEALTH STATE-BY-STATE POLICIES, LAWS & REGULATIONS



Search by Category & Topic

Medicaid Reimbursement

- Live Video
- Store & Forward
- Remote Patient Monitoring Reimbursement

Private Payer Reimbursement

- Private Payer Laws
- Parity Requirements

Professional Regulation/Health & Safety

- Cross-State Licensing
- Consent
- Prescribing
- Misc (Listing of Practice Standards)

FEDERAL AND STATE DEVELOPMENTS

FEDERAL

- MEDICARE 2019 CHANGES
- MEDICARE PROPOSED 2020 PFS CHANGES
- FEDERAL LEGISLATION
- OTHER FEDERAL CHANGES

STATE DEVELOPMENTS

- STATE LEGISLATION
- CURRENT STATE POLICY

MEDICARE FEE-FOR-SERVICE/ORIGINAL MEDICARE

SOCIAL SECURITY ACT OF 1835(m) or 42 USC 1395m

- Only Live Video reimbursed
- Store & Forward (Asynchronous) only for Alaska & Hawaii demonstration pilots
- Specific list of providers eligible for reimbursement
- Limited to rural HPSA, non-MSA, or telehealth demonstration projects
- Limited types of facilities eligible
- Limited list of reimbursable services, but CMS decides what can be delivered via telehealth and reimbursed

TWO 2018 FEDERAL BILLS

- BIPARTISAN BUDGET ACT 2018
- SUPPORT FOR PATIENTS AND COMMUNITIES ACT

WHAT DID THEY DO?

BIPARTISAN BUDGET ACT 2018

- Expanded to add Renal Dialysis Facilities & the home for ESRD-services ONLY.
- Rural limitation not apply for ESRD services in hospital-based or CAH-based renal dialysis centers, renal dialysis facilities or home.
- Acute stroke service via telehealth may take place in currently eligible originating sites and mobile stroke unit or any location deemed appropriate by Secretary. Renal Dialysis Facilities & home are excluded.
- For acute stroke diagnosis, evaluation and treatment of symptoms, originating site limitations not apply.

SUPPORT ACT 2018

- CMS must adjust policies on telehealth reimbursement for treating individuals with SUDs or a co-occurring mental health disorder.
- Removed the originating site geographic requirements for telehealth services for any existing Medicare telehealth originating site (except for a renal dialysis facility).
- Home was made an eligible originating site for purposes of treating these individuals, however the home would not qualify for the facility fee.
- Within 5 years a report of the impact of telehealth services on SUD must be submitted by the Secretary.
- Goes into effect July 1, 2019.

MEDICARE FEE-FOR-SERVICE/ORIGINAL MEDICARE

Telehealth Policy Only – Services

- Added codes for telehealth reimbursement
- CMS may add new codes for reimbursement every year
- Decision to add new codes depends on whether the services fall into one of two potential categories
- For CY 2019 added two codes:
  - G0513 and G0514 - Prolonged preventive service(s) (beyond the typical service time of the primary procedure), in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes or for each additional 30 minutes
- **No additional codes suggested to be added for CY 2020**

MEDICARE – REMOTE PHYSIOLOGIC MONITORING

Telehealth Technologies used to deliver care, but not called a telehealth service

- Added codes for remote physiological monitoring:
  - CPT code 99453 - Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.
  - CPT code 99454- Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days.
  - CPT code 99457- Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

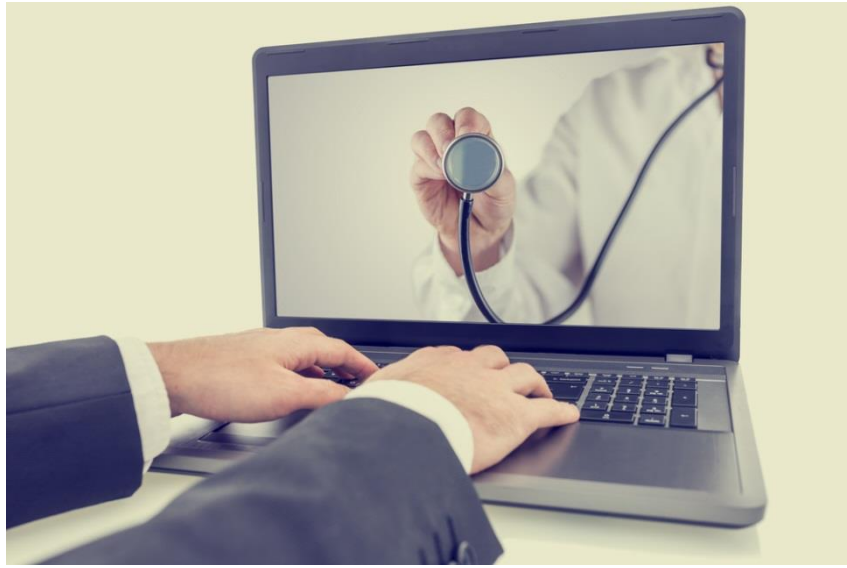
MEDICARE – Communication Technology-Based Services

Services furnished remotely using communications technology are not considered "Medicare telehealth services" and are not subject to the restrictions articulated in section 1834(m) of the Act. ~ CMS, Federal Register, November 1, 2018.

- Brief Communication Technology-based Service or Virtual Check-In
- Remote Evaluation of Pre-Recorded Patient Information
- Interprofessional Internet Consultation

VIRTUAL CHECK-IN

- G2012 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- May be done over phone
- Only for established patients
- Must have verbal consent
- Patient will be responsible for any co-payment/deductible



REMOTE EVALUATION OF PRE-RECORDED PATIENT INFORMATON

- G2010 - Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment.
- Only for established patients
- Patient will be responsible for any copayment/deductible

INTERPROFESSIONAL INTERNET CONSULTATION

- **99446 - 99449** - Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-31 minutes of medical consultative discussion and review (depending on code).
- **99452** - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.
- **99451** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time.
- Verbal consent required
- Cost sharing with patient needs to be disclosed
- Can be through phone or internet

OPIOIDS/SUBSTANCE USE DISORDER

OTHER SUD/OPIOID RELATED POLICIES

- Within one year the DEA must have final regulations for a special registration to remotely prescribe Suboxone/Buprenorphine through telehealth.
- DEA will likely not finalize regulations until at the deadline of the end of 2019.
- Possibly see drafts/proposed regulations soon.

MEDICARE ADVANTAGE

- Medicare Advantage (MA) plans are now allowed to cover Part A and B services when delivered via telehealth.
- MA plans decide what services can be offered, as long as they are services covered under Part A and B.
- If the services are not typically covered under Part A and B, MA plans may offer those services via telehealth but will be covered under supplemental plans.
- Modalities are broadly defined.
- Geographic and facility restrictions found in Medicare fee-for-service do not apply.
- Limitations on type of providers who can provide these additional telehealth benefits will continue to apply.
- Must use credentialed, contracted network providers.
- All relevant state laws will apply.
- Not mandatory for MA plans to offer to cover more services beyond what is required in fee-for-service.
- Does not go into effect until 2020.

PROPOSED 2020 PHYSICIAN FEE SCHEDULE

- **3 NEW CODES TO TREAT OUD VIA TELEHEALTH**
  - *HCPCS code GYYY1: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.*
  - *HCPCS code GYYY2: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.*
  - *HCPCS code GYYY3: Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).*
- **OPIOID TREATMENT PROGRAMS (OTPs)**
  - Starting Jan 1, 2020, OTPs can provide counseling and group therapy via telehealth via live video. Geographic limitations and other statutory telehealth restrictions would not apply. Services would not be separately billed, but part of the bundled payment.

PROPOSED 2020 PHYSICIAN FEE SCHEDULE

- **CHRONIC CARE MANAGEMENT**
  - ***GCCC1 (Replaces 99490)****: Initial 20 minutes of clinical staff time*
  - ***GCCC2 (Replaces 99490)****: Each additional 20 minutes of clinical staff time*
  - ***GCCC3 & GCCC4****: Used in place of 99487 & 99489 for establishing and revising a comprehensive care plan.*

PROPOSED 2020 PHYSICIAN FEE SCHEDULE

- **PRINCIPAL CARE MANAGEMENT (PCM)**
  - New code for care management of one serious chronic condition that is expected to last between 3 months and a year or until death, may have led to recent hospitalization and/or place the patient at significant risk of death, functional decline. Services include coordination of medical and/or psychosocial care provided by a physician or clinical staff under direction of a physician or other qualified health professional.
    - ***GPPP1*** *- Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.*
    - ***GPPP2*** *- Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.*

PROPOSED 2020 PHYSICIAN FEE SCHEDULE

- **REMOTE PHYSIOLOGIC MONITORING**

  Existing code 99457 still exists and is for the first 20 minutes of treatment services.

  New code 994X0 is an add on code for subsequent 20 minute intervals.

  Services can be delivered with general supervision of auxiliary personnel by a physician or other qualified health care professional.

- **CONSENT FOR COMMUNICATION TECHNOLOGY-BASED SERVICES**

  CMS seeking comment on the possibility of obtaining advance consent for a number of communication technology-based services. Currently required to get consent for each service delivered through these technologies.

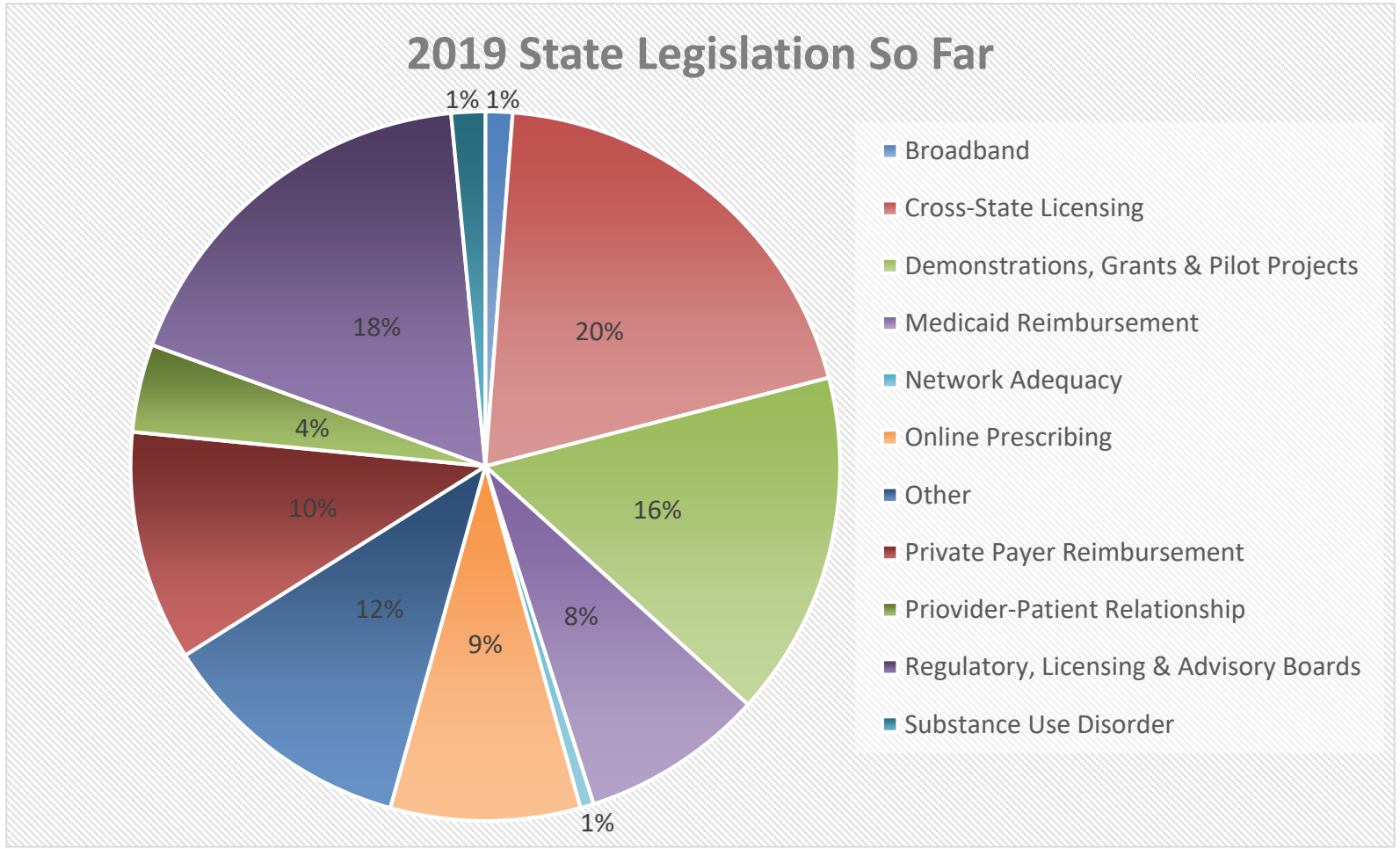
CURRENT FEDERAL LEGISLATION

- The BETTER Act
  - Allows more mental health services to be delivered in the home via telehealth under Medicare program
- S. 1037 – Rural Health Clinic Modernization Act
  - Would allow RHCs to act as distant site providers in Medicare
- HR 1301 – Mental Health Telemedicine Expansion Act
  - Medicare beneficiaries allowed to access psychotherapy services—specifically CPT 90834 (45 minutes) and 90837 (60 minutes)—through real-time, interactive audio and video telecommunications with a patient; allow home and no geographic limitation
- HR 2452 – Medicare for America Act
  - Would include telehealth as a service benefit

FCC PROPOSED PILOT

- $100 Million/approximately 20 pilots
- Targeting Rural and Underserved areas
- Interested in the use of RPM
- Paying for the connectivity/approximately 85% of the cost
- Targeting CHCs to apply
- Soliciting feedback on design
- Comments Due August 29, 2019

2019 STATE LEGISLATIVE TRENDS



STATE LEGISLATION/REGULATIONS

- **AK** – Proposed Changes to Medicaid Regs (August 2, 2019)
- **ID** – Board of Medicine 22.01.15 Rules Relating to Telehealth Services (Nov 7, 2018)
- **MT** – **HB 518** - Use of telemedicine to supervise PT assistants, aides, students
- **OR** – Medicaid Teledentistry Rules Regarding Criteria and Protocol (Nov 2, 2018)
- **UT – HB 8** – Appropriates funds to the UT Education & Telehealth Network
- **WA – SB 5387** – Amends requirements for provider credentialing related to telemedicine services

MEDICAID REIMBURSEMENT BY SERVICE MODALITY

Live Video

50 states and DC

Store and Forward

Only in 11 states

Remote Patient Monitoring

20 states

REIMBURSEMENT REQUIREMENTS FOR PRIVATE PAYERS

39 states and DC

have telehealth **private payer** laws

Some go into effect at a later date.

Parity is difficult to determine:

-Parity in services covered vs. parity in payment

-many states make their telehealth private payer laws "subject to the terms and conditions of the contract"

ALASKA

CURRENT STATE

- Medicaid – Live Video, S&F & RPM Reimbursement
- Medicaid – Require some specific documentation elements such as names of people participating in encounter
- No private payer law
- Dept of Commerce, Community and Economic Development is required to adopt regulations for establishing and maintaining a registry of businesses performing telemedicine in the state.

IDAHO

CURRENT STATE

- Medicaid – Live Video Reimbursement
- Medicaid – Specific list of eligible providers (does include PTs, OTs & Speech language pathologists)
- Medicaid – An appropriate consent is required, which must disclose the delivery models, provider qualifications, treatment methods, or limitations and telehealth technologies.
- No Private Payer Law
- Licensure Compact Member
  - Medical Licensure
  - Nurse Licensure

MONTANA

CURRENT STATE

- Medicaid – Live Video Reimbursement
- Medicaid – Allows originating site to be member's residence
- Medicaid – Originating and distant site providers may not be w/in same facility or community or have same tax ID number
- Private Payer law does exist – Specific list of providers & facilities
- Licensure Compact Member
  - Medical Licensure
  - Nurse Licensure
  - PT Compact

OREGON

CURRENT STATE

- Medicaid – Live Video Reimbursement
- Medicaid – Allows use of phone, email and fax under certain circumstances
- Medicaid – Reimburses for teledentistry
- Private Payer law does exist

UTAH

CURRENT STATE

- Medicaid – Live Video Reimbursement
- Medicaid – RHC/FQHC services may be delivered via telehealth
- Private Payer law
- An out-of-state physician may practice without a Utah license if:
  - The physician is licensed in another state, with no licensing action pending and at least 10 years of professional experience;
  - The services are rendered as a public service and for a noncommercial purpose;
  - No fee or other consideration of value is charged, expected or contemplated, beyond an amount necessary to cover the proportionate cost of malpractice insurance;
  - The physician does not otherwise engage in unlawful or unprofessional conduct.

WASHINGTON

CURRENT STATE

- Medicaid – Live Video, S&F & RPM Reimbursement
- Medicaid – RHCs are not allowed to be distant site providers
- Private Payer law does exist
- Licensure Compact Member
  - Medical Licensure
  - PT Compact

WYOMING

CURRENT STATE

- Medicaid – Live Video Reimbursement
- Medicaid – Manual has a specific list of eligible services and providers
- No Private Payer law
- Licensure Compact Member
  - Medical Licensure
  - Nurse Licensure

RESOURCES

Center for Connected Health Policy
www.cchpca.org

Telehealth Resource Center
www.telehealthresourcecenter.org

THANK YOU!