HOUSE BILL REPORT
ESHB 1196

As Passed Legislature

Title: An act relating to audio-only telemedicine.

Brief Description: Concerning audio-only telemedicine.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Riccelli, Callan, Bateman, Ramos, Cody, Ortiz-Self, Duerr, Harris, Leavitt, Bergquist, Shewmake, Fitzgibbon, Macri, Tharinger, Slatter, Davis, Berg, Pollet, Orwall, Harris-Talley and Frame).

Brief History:

Committee Activity:

Health Care & Wellness: 1/25/21, 2/3/21 [DPS].

Floor Activity:

Passed House: 2/24/21, 94-3.
Senate Amended.
Passed Senate: 4/10/21, 45-4.
House Concurred.
Passed House: 4/15/21, 96-0.
Passed Legislature.

Brief Summary of Engrossed Substitute Bill

- Requires reimbursement for audio-only telemedicine services.
- Expands the definition of telemedicine for purposes of hospital privileging to include audio-only telemedicine services.
- Requires the Insurance Commissioner and the Collaborative for the Advancement of Telemedicine to study and make recommendations regarding telemedicine.

HOUSE COMMITTEE ON HEALTH CARE & WELLNESS

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

Majority Report: The substitute bill be substituted therefor and the substitute bill do pass. Signed by 11 members: Representatives Cody, Chair; Bateman, Vice Chair; Schmick, Ranking Minority Member; Bronoske, Davis, Harris, Macri, Riccelli, Simmons, Stonier and Tharinger.

Minority Report: Do not pass. Signed by 1 member: Representative Caldier, Assistant Ranking Minority Member.

Minority Report: Without recommendation. Signed by 3 members: Representatives Maycumber, Rude and Ybarra.

Staff: Jim Morishima (786-7191).

Background:

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.

I. Telemedicine Reimbursement.

A health plan offered by a health carrier, a health plan offered to school or state employees and their dependents, a Medicaid managed care plan, or a behavioral health administrative services organization (for covered persons under 18 years of age) 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, or a home.

A health plan offered by a health carrier, a health plan offered to school or state employees, and a Medicaid managed care plan must reimburse a provider for a health care service provided through telemedicine at the same rate as if it was provided in person. Hospitals, hospital systems, telemedicine companies, and provider groups of 11 or more providers may negotiate a different reimbursement rate.

For purposes of these requirements, telemedicine does not include the use of audio-only

telephone, facsimile, or electronic mail (e-mail).

II. Hospital Privileging.

A hospital may grant privileges to physicians to treat patients in its facilities. When a patient is being treated through telemedicine, an originating site hospital may rely on a distant site hospital's decision to grant or renew the privileges or association of any physician providing telemedicine services if the originating site hospital has a written agreement with the distant site hospital. The definition of "telemedicine" for this purpose does not include audio-only telephone, facsimile, or e-mail.

III. The Collaborative for the Advancement of Telemedicine.

Hosted by the University of Washington, the Collaborative for the Advancement of Telemedicine (Collaborative) is a group convened to develop recommendations on telemedicine. Issues the Collaborative considers include reimbursement, access, best practices, and technical assistance. The Collaborative expires on December 31, 2021.

Summary of Engrossed Substitute Bill:

I. Telemedicine Reimbursement.

A health plan offered by a health carrier, a health plan offered to school or state employees and their dependents, a Medicaid managed care plan, or a behavioral health administrative services organization (for covered persons under 18 years of age) must reimburse providers for health care services provided through audio-only telemedicine under the same conditions applicable to audio-video telemedicine.

If a provider intends to bill for audio-only telemedicine, he or she must first obtain the patient's consent to the billing prior to the service being delivered. A pattern of potential violations of the consent requirement must be reported to the provider's disciplining authority and the provider must be given the opportunity to cure or explain the violations. The disciplining authority may levy a fine or cost recovery and take any other action as permitted under its statutory authority. Upon completion of its review, the disciplining authority notify the Insurance Commissioner or the Health Care Authority (HCA), as appropriate, of the results of the review.

Beginning January 1, 2023, the audio-only telemedicine reimbursement requirement applies only if the covered person has an established relationship with the provider. An established relationship exists if the person has had at least one in-person appointment within the past year with the audio-only telemedicine provider or a provider in the same clinic or the covered person was referred by another provider who has had at least one in-person appointment with the person within the past year and has given relevant medical information to the audio-only telemedicine provider.

A health plan offered by a health carrier, a health plan offered to school or state employees, and a Medicaid managed care plan must reimburse a provider for a health care service provided through telemedicine the same amount of compensation that would have been paid to the provider if the service was provided in person. Medicaid managed care organizations must reimburse rural health clinics for audio-only telemedicine at the rural health clinic encounter rate. A hospital acting as an originating site may not charge a facility fee for audio-only telemedicine.

Medicaid providers wishing to bill for audio-only telemedicine must comply with rules created by the HCA relating to restrictions on billing Medicaid recipients. The HCA may take actions against a Medicaid provider's participation agreement.

The HCA must adopt rules requiring Medicaid fee-for-service reimbursement for audio-only telemedicine services. The rules must establish a manner of reimbursement that is consistent with Medicaid managed care, except that rural health clinics must be reimbursed at the encounter rate.

For purposes of these requirements, "audio-only telemedicine" means the delivery of health care services through the use of audio-only technology, permitting real-time communication between the patient at the originating site and the provider for purposes of diagnosis, consultation, or treatment. Audio-only telemedicine does not include facsimile, electronic mail or the delivery of health care services that are customarily delivered by audio-only technology and not billed as separate services by the provider, such as the sharing of laboratory results.

The Insurance Commissioner may adopt any rules necessary to implement telemedicine requirements applicable to health carriers.

II. Hospital Privileging.

The definition of telemedicine for purposes of hospital privileging is expanded to include audio-only telemedicine.

III. The Collaborative for the Advancement of Telemedicine.

The termination date for the Collaborative for the Advancement of Telemedicine is extended from December 31, 2021, to December 31, 2023.

IV. Telemedicine Studies.

The Insurance Commissioner, in collaboration with the Collaborative for the Advancement of Telemedicine and the HCA, must study and make recommendations regarding:

- preliminary utilization trends for audio-only telemedicine;

- qualitative data from health carriers, including Medicaid managed care organizations, on the burden of compliance and enforcement requirements for audio-only telemedicine;
- preliminary information regarding whether requiring reimbursement for audio-only telemedicine has affected the incidence of fraud;
- proposed methods to measure the impact of audio-only telemedicine on access to health care services for historically underserved communities and geographic areas; and
- an evaluation of the relative costs to providers and facilities of providing audio-only telemedicine services compared to audio-video telemedicine services and in-person services.

The Insurance Commissioner must report findings and recommendations to the appropriate committees of the Legislature by November 15, 2023.

The Collaborative for the Advancement of Telemedicine must study the need for an established patient/provider relationship for audio-only telemedicine and submit recommendations to the Legislature by December 1, 2021.

V. Fraud.

Nothing in the act alters the requirement for the HCA to report potential fraud to the Attorney General.

Appropriation: None.

Fiscal Note: Preliminary 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) This bill expands telemedicine reimbursement to include audio-only telemedicine. Audio-only telemedicine reimbursement has been a critical lifeline during the pandemic. It has ensured continued access to care and its increased use may be one of the only positives to come out of the pandemic. Emergency orders adopted by the Insurance Commissioner have required audio-only telemedicine reimbursement, but there will be continuing need after the emergency. Audio-only telemedicine has become a reliable way for people to contact their doctors and helps them address exigent circumstances. This helps avoid the misuse of downstream resources.

This is an equity issue. Audio-only telemedicine may be the only option in some rural areas and for persons with limited access to, or proficiency with, technology. The established

relationship requirement in this bill may present a barrier and may need to be refined. It would be a step back if this bill were not enacted.

Quality, appropriate care can be provided through audio-only telemedicine, which should be reimbursed at parity—providers are performing the same services and providing the same care as in an in-person visit. Telemedicine is one of the best tools in the toolbox. There is evidence that audio-only telemedicine is just as effective as in-person services like cognitive behavioral therapy. Audio-only telemedicine may be a better option for teens who may be sensitive about their appearance. Video often presents barriers to patients and can cause visits to last longer than they should. When video access is unstable, patients may have to switch to audio-only. Lack of access to video cuts off care.

Proxy credentialing for hospitals should be addressed by this bill. Programs administered by the Department of Labor and Industries should be added to this bill. There are federal grants to help people with connectivity issues.

(Opposed) None.

(Other) The pandemic has shown the importance of virtual care, including audio-only telemedicine. Audio-only telemedicine may not be effective outside of behavioral health, so this bill should be limited accordingly—other services can be added over time. This bill should be harmonized with existing telemedicine statutes. Broadband access needs to be addressed. The established relationship requirement should be removed from this bill, because it will present a barrier to care. There is no evidence that an in-person visit would be beneficial. Health maintenance organizations have a long history with audio-only telemedicine through programs like consulting nurse lines. However, it is usually provided as part of integrated care and not for extra payment. Rather than parity, this bill should take an equity approach that makes care more affordable. A broader approach with the patient-provider relationship would be better.

Companies that provide telemedicine services are proud of their contribution. They save patients and payors millions of dollars. Telemedicine is the sharpest tool in the toolbox and must be made accessible to all. The approach should be technology-neutral and hinge on the standard of care.

Persons Testifying: (In support) Representative Riccelli, prime sponsor; Jeb Shepard and Katina Rue, Washington State Medical Association; Jim Freeburg; Jane Beyer, Office of the Insurance Commissioner; John Scott, University of Washington; Ian Randall, Washington Association for Community Health; Lisa Thatcher, Washington State Hospital Association; Melanie Smith, Washington State Psychological Association; Crystal Shen, Washington Chapter of the American Academy of Pediatrics; and Jennifer Stoll, OCHIN.

(Other) Claudia Tucker, Teladoc Health, Inc.; Chris Bandoli, Association of Washington Healthcare Plans; Marissa Ingalls, Coordinated Care; and Courtney Smith, Kaiser

Permanente.

Persons Signed In To Testify But Not Testifying: None.