SENATE BILL REPORT
ESHB 1448

As of March 29, 2013

Title: An act relating to telemedicine.

Brief Description: Regarding telemedicine.

Sponsors: House Committee on Health Care & Wellness (originally sponsored by Representatives Bergquist, Ross, Cody, Harris, Green, Rodne, Tharinger, Johnson, Manweller, Magendanz and Morrell).

Brief History: Passed House: 3/06/13, 74-23.
Committee Activity: Health Care: 3/27/13.

SENATE COMMITTEE ON HEALTH CARE

Staff: Mich'l Needham (786-7442)

Background: Telemedicine is the use of electronic communications to provide health care services to a patient at a distance. Electronic communication is accomplished through audio-visual equipment permitting real-time, interactive interaction between the patient at the originating site and the provider at the distant site.

The Uniform Medical Plan covers telemedicine, but only in professional shortage areas as defined by the federal government. The state's Medicaid program also covers telemedicine in certain circumstances. For example, Medicaid reimburses home health agencies for skilled home health visits delivered via telemedicine. Private health carriers are currently not required to cover telemedicine services.

Under federal Medicare regulations, when health care services are provided by a physician through telemedicine, the originating site hospital may choose to rely on the privileging decisions made by the distant site hospital if:

- the distant site hospital participates in Medicare;
- the physician is privileged at the distant site hospital;
- the physician is licensed by the state in which the originating site hospital is located; and
- the originating site hospital has evidence of an internal review of the distant site physician's performance and sends the distant site hospital information on the physician's performance for use in the distant site's periodic appraisal of the

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physician. The information must include all adverse events that result from the telemedicine services and all complaints the originating site hospital has received about the physician.

Prior to granting privileges to a physician, a hospital must:

1. obtain the following information from the physician:
    a. the names of any hospital or facility at which the physician had any association, employment, privileges, or practice;
    b. information regarding any pending professional medical misconduct proceedings or any pending medical malpractice actions, including the substance of the findings in those actions or proceedings;
    c. a confidentiality waiver; and
    d. a verification that the information is accurate and complete; and
2. obtain the following information from any hospital or facility at which the physician had any association, employment, privileges, or practice:
    a. any pending professional misconduct proceedings or any pending medical malpractice actions;
    b. any judgment or settlement of a medical malpractice action and any finding of professional misconduct; and
    c. any information the hospital or facility is required to report to the Medical Quality Assurance Commission (MQAC) in connection to physician discipline.

Summary of Bill: Health insurance carriers, including health plans offered to state employees, must reimburse a provider for a health care service delivered through telemedicine on the same basis and at the same rate that the health carrier or plan would reimburse for the same service provided in person, and must also reimburse an originating site for the infrastructure and preparation of the patient for telemedicine services, if:

- the plan provides coverage of the health care service when provided in person;
- the health care service is medically necessary; and
- the health care service does not duplicate or supplant a health care service that is available in person.

A health carrier may not distinguish between originating sites that are rural and urban. An originating site for telemedicine includes, but is not limited to, a hospital, a rural health clinic, a federally qualified health center, a physician's office, a community mental health center, a skilled nursing facility, a renal dialysis center, or a site where public health services are provided.

A health carrier may subject telemedicine services to all terms and conditions of the plan applicable to in-person services, including utilization review, deductibles, copayments, or coinsurance. Reimbursement is not required for a health care service that is not a covered benefit, for providers who are not covered under the plan, or for professional fees to the originating site.

Telemedicine is defined as the use of interactive audio, video, or electronic media for the purpose of diagnosis, consultation, or treatment. The term does not include the use of audio-only telephone, facsimile, or electronic mail. Originating site is defined as the physical location of a patient receiving health care services through telemedicine, which prepares the

patient for the telemedicine services and provides the infrastructure for the telemedicine services to occur.

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 that assures the following:

- the distant site hospital providing the telemedicine services is a Medicare-participating hospital;
- any physician providing telemedicine services at the distant site hospital is fully privileged to provide such services by the distant site hospital;
- any physician providing telemedicine services holds and maintains a valid license to perform such services issued or recognized by Washington; and
- the originating site hospital has evidence of an internal review of the distant site physician's performance and sends the distant site hospital performance information for use in the periodic appraisal of the distant site hospital. The information must include all adverse events that result from the telemedicine services and all complaints the originating site hospital has received about the physician.

MQAC, the Nursing Care Quality Assurance Commission (NCQAC), and the Board of Osteopathic Medicine and Surgery (BOMS) must develop policies to allow out-of-state health care providers to deliver telemedicine services to Washington residents. The policies must ensure the quality of services delivered and the safety of patients. Throughout the year, MQAC, NCQAC, and BOMS must meet to coordinate their efforts in developing the policies. By December 1, 2013, the Department of Health must provide a progress report on these efforts to the appropriate committees of the Legislature.

Appropriation: None.

Fiscal Note: Available.

Committee/Commission/Task Force Created: No.

Effective Date: Sections 1-5 take effect January 1, 2014. Section 6 takes effect ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: There is a patchwork approach to telemedicine today and we are trying to make a consistent approach and improve access to care. The physician time with the patient is valuable and should be paid at parity in person or via telemedicine. We believe there will be an increased demand for access to care with health reform and it is important to expand access to care for all patients. Telemedicine can help us expand access and should be reimbursed. I would love to see an amendment to including telemonitoring for patients receiving home care and hospice. The technology can help keep patients healthy and help avoid emergency room use and hospital use. The telemonitoring results in better patient outcomes. The Department of Labor and Industries (L&I) struggles to find access to specialty services and telemedicine can help us ensure timely access.

Our rural hospital has used telehealth services for three years. It allows us to provide services such as a virtual stroke assessment within the critical window of time, and it allows

us to retain patients in the community while accessing specialty services for them. Currently, the hospital pays for the consultation service. As a patient advocate we want to provide access to treatment in a timely way. We facilitate the service because it improves patient health and saves time for the patient and provider that would otherwise be spent traveling. It ensures that the rural community has access to the specialty care they need.

Some mental health therapies are delivered through telehealth as an integral part of therapy. Research documents the reduction in other patient costs. Highly trained professionals are not available everywhere and the specialty mental health services are hard to access face to face in a timely way. The time spent with the patient is equally valuable and should be paid equally. We provide a telestroke service and it is critical to get patients evaluated very quickly and begin treatment rapidly. Time is brain for stroke – the number one cause of disability in our country. The technology is very sophisticated and allows a very detailed review. I should be reimbursed for the time evaluating the patient – sometimes it is more intense than an in-person visit and yet I am not paid for the service. There is a shortage of stroke neurologists and this service is critical for time and treatment. Treatment for covered services should be at parity to help us ensure access to care for patients when then need it. Access to a range of specialty services can be provided much more efficiently and more timely through telehealth. Waiting times for in-person visits can be quite delayed, but the service needs to be reimbursed since it is taking time away from available office hours. It can help build capacity for services and improve access.

CON: We support telehealth but oppose the bill with the parity requirement. We would not opposed it without the parity requirement. We need to be allowed to continue our negotiations between private parties to reach agreement on the reimbursement amounts. A one size fits all requirement does not work. We are also in a transition away from fee-for-service billing and this type of language ties us to an old model. Many insurance carriers pay for telemedicine services today, subject to private contractual agreements. We are all professionals capable of negotiating agreements. Telehealth does not need to be treated differently than any other covered service. The new technology may result in some cost savings and efficiencies and the consumers should enjoy the efficiencies.

OTHER: Telehealth can help create timely access to care. Consider broadening the definition of telehealth to include a broader scope with model language.

Persons Testifying: PRO: Representative Berquist, prime sponsor; Melissa Johnson, WA State Nurses Assn.; Leslie Emerick, Home Care Assn. of WA, WA State Hospice and Palliative Care Organization; Leah Hole-Curry, L&I; Tim Martin, Dr. Bob Sinclair, Lincoln County Public Hospital District; Lucy Homans, WA State Psychological Assn.; Dr. James McDowell, Providence; Katy Kolan, WA State Medical Assn.; Cara Towle, Roy Colven, David Tauben, University of WA; Katherine Flynn, Seattle Children's Hospital.

CON: Chris Bandoli, Regence BlueShield; Mel Sorensen, Americas Health Insurance Plans; Len Sorrin, Premera Blue Cross.

OTHER: Rebecca Johnson, Planned Parenthood Votes Northwest.