Proposed Language addition to Maine 333

Additions in Red

130th MAINE LEGISLATURE

FIRST REGULAR SESSION-2021

Legislative Document No. 333

H.P. 237 House of Representatives, February 8, 2021

An Act Regarding Telehealth

Received by the Clerk of the House on February 4, 2021. Referred to the Committee on Health Coverage, Insurance and Financial Services pursuant to Joint Rule 308.2 and ordered printed pursuant to Joint Rule 401.

ROBERT B. HUNT

Clerk

Presented by Representative HYMANSON of York.

Be it enacted by the People of the State of Maine as follows:

Sec. 1. 24 MRSA §2904, sub-§1, ¶A, as amended by PL 2019, c. 289, §1, is further amended to read:

A. A licensed health care practitioner who voluntarily, without the expectation or receipt of monetary or other compensation either directly or indirectly, provides professional services, including services provided through telehealth as defined in Title 24-A, section 4316, subsection 1, paragraph E C, within the scope of that health care practitioner's licensure:

(1) To a nonprofit organization;

(2) To an agency of the State or any political subdivision of the State;

(3) To members or recipients of services of a nonprofit organization or state or local agency;

(4) To support the State's response to a public health threat as defined in Title 22, section 801, subsection 10;

(5) To support the State's response to an extreme public health emergency as defined in Title 22, section 801, subsection 4-A; or

(6) To support the State's response to a disaster as defined in Title 37-B, section 703, subsection 2;

B. A licensed health care practitioner engaging in telehealth shall make a good faith effort to directly contact and coordinate with emergency services in accordance with the standard of care and the written emergency care plan that is appropriate to the situation and to the services rendered through the telehealth encounter. The emergency care plan shall pertain to areas where patients are located during a telehealth encounter and shall use a method with response and equivalent priority to a 9-1-1 dialed call or better. A licensed health care practitioner engaging in telehealth shall make a good faith effort to: provide the name and location of the patient to emergency services in oral and written form; determine the location of a patient if a patient is unaware of his or her location; and provide his or her contact information to emergency services. Consent may be implied, oral, written, or digital in nature, provided that the chosen method of consent is deemed appropriate under the

standard of care. A licensed health care practitioner engaging in telehealth shall report suicide attempts of patient during a telehealth encounter to the Department of Health in a manner that is consistent with federal and State privacy laws emergency and document emergencies which occur during a telehealth encounter.

Sec. 2. 24-A MRSA §4316, sub-§1, ¶C, as enacted by PL 2019, c. 289, §2, is amended to read:

C. "Telehealth," as it pertains to the delivery of health care services, means the use of interactive real-time visual and audio or other electronic media for the purpose of consultation and education concerning and diagnosis, treatment, care management and self-management of an enrollee's physical and mental health and includes real-time interaction between the enrollee and the telehealth provider, synchronous encounters, asynchronous encounters, store and forward transfers and telemonitoring. "Telehealth" includes the use of audio-only telephone when no means of interactive real-time visual and audio or other electronic media are available to the enrollee due to lack of such electronic media or of adequate broadband access or when the use of other means of interactive real-time visual and audio or other electronic media is infeasible, impractical or otherwise not medically advisable, as determined by the provider providing telehealth services to the enrollee or as determined by another provider with an existing relationship with the enrollee. "Telehealth" does not include the use of audio-only telephone, facsimile machine, e-mail or texting.

Sec. 3. 24-A MRSA §4316, sub-§1, ¶E, as enacted by PL 2019, c. 289, §2, is repealed.

Sec. 4. 24-A MRSA §4316, sub-§2, as corrected by RR 2019, c. 2, Pt. A, §28, is amended to read:

2. Parity for telehealth services. A carrier offering a health plan in this State may not deny coverage on the basis that the health care service is provided through telehealth if the health care service would be covered if it were provided through in-person consultation between an enrollee and a provider. Coverage for health care services provided through

telehealth must be determined in a manner consistent with coverage for health care services provided through in-person consultation. A carrier shall reimburse a provider for the diagnosis, consultation with or treatment of an enrollee delivered through telehealth services on the same basis and at least at the rate of reimbursement at which the carrier reimburses a provider for the provision of the same, or substantially similar, service through in-person consultation. If an enrollee is eligible for coverage and the delivery of the health care service through telehealth is medically appropriate, a carrier may not deny coverage for telehealth services. A carrier may not offer a health plan under which any deductible applied to health care services delivered through telehealth accumulates separately from the deductible that applies in the aggregate to all services covered under the health plan. A carrier may offer a health plan containing a provision for a deductible, copayment or coinsurance requirement for a health care service provided through telehealth as long as the deductible, copayment or coinsurance does not exceed the deductible, copayment or coinsurance applicable to a comparable service provided through in-person consultation. A carrier may not exclude a health care service from coverage solely because such health care service is provided only through a telehealth encounter, as long as telehealth is appropriate for the provision of such health care service.

A carrier will not be required to reimburse a treating or consulting healthcare provider for a telehealth encounter which does not have an

active emergency plan in place or without coordination of patient emergencies appropriate to the situation.

Sec. 5. 24-A MRSA §4316, sub-§3, ¶G is enacted to read:

G. The carrier may not place any restriction on the prescribing of medication through telehealth by a provider whose scope of practice includes prescribing medication that is more restrictive than any requirement in state and federal law for prescribing medication through in-person consultation.

Sec. 6. 24-A MRSA §4316, sub-§5, as enacted by PL 2019, c. 289, §2, is repealed.

Sec. 7. 24-A MRSA §4316, sub-§6, as enacted by PL 2019, c. 289, §2, is amended to read:

6. Utilization review. This section does not prohibit or limit a carrier from conducting a utilization review for telehealth services as long as the utilization review is conducted in the same manner, is applied no more stringently and uses the same clinical review criteria as a utilization review for an in-person consultation for the same service.

Sec. 8. Application. The requirements of this Act apply to health plans, as defined in the Maine Revised Statutes, Title 24-A, section 4301-A, subsection 7, executed, delivered, issued for delivery, continued or renewed in this State on or after January 1, 2022. For purposes of this Act, all health plan contracts are deemed to be renewed no later than the next yearly anniversary of the contract date.

SUMMARY

This bill makes changes to the provisions governing health insurance coverage of telehealth services.

1. It authorizes the delivery of health care services through telehealth by audio-only telephone.

2. It clarifies that reimbursement for telehealth services must be made on the same basis and at the same rate as if the services were delivered in person.

And here is the reason for the language:

Patient Case:

Our primary care telehealth practice has been seeing a patient for the past year. Late January she told her psychiatrist over telehealth she was going to kill herself. The psychiatrist said this was an emergency and told the patient to “hang up and call 911” to receive in-patient care. They hung up and the patient did not call 911. A few days later she called her psychologist, said she was going to kill herself by taking pills, and again was told to “hang up and call 911.” The patient didn't call.

On Tuesday afternoon the next week, she took a whole bottle of hydroxyzine pills. A few minutes later she called our telehealth practice in Little Falls, NJ and told us she had done something stupid. She is normally in Bergen county but this week she was in Toms River. We have emergency telehealth protocols and were able to activate 911 in Toms River. She became altered to the point she could not open the front door, so our providers coordinated with police and EMS to enter and identify the pills. She made it to the emergency department and survived. The psychologist and psychiatrist had no idea what happened until we called them a few days later.

Although our practice activated 911 and handed off care, this was not a success because she overdosed and there was patient harm. If our practice had not remotely activated 911 she might have died in this attempt or the next. In-person coordination and hand-off of care does reliably happen in hospitals, clinics, and other facilities, however many telehealth programs ask patients who are in emergencies to “hang up and go to the ER or call 911.” Hand-off and transition of care has been shown to reduce

medical error by 30% and reduce adverse events by 21%. The Joint Commission says the best handoff uses both verbal and written communication. Telehealth Emergencies are no different than in-person emergencies, strong hand-off is needed and saves lives. Suicide is the 10th leading cause of death in the US and the leading reason to activate 911 for telehealth, followed by Shortness of Breath and Altered Mental Status.

After this happened a nurse practitioner and a doctor from our practice reached out to this behavioral health practice to help them with their telemedicine emergency protocols and methods. The providers replied “we will consider it.” They still don’t have protocol for activating 911 except to ask patients to call 911 themselves. The patient who attempted suicide is still in the hospital and will be transferred to Florida for inpatient treatment. She is luckier than the other two who killed themselves in Bergen County this past year after telehealth visits. One jumped off a building and the other jumped off a bridge.

Many New Jersey hospitals and practices have great telehealth emergency protocols or technology to reliably handoff and transition care to emergency services when telehealth emergencies happen. And, many do not.