

APPENDIX



Testimony in Support of Using Telemedicine Technology

TO: New Jersey Senate Health, Human Services & Senior Citizens Committee
FROM: Dr. Christopher Haines, Chief Medical Officer, Children's Specialized Hospital
DATE: November 9, 2015

Thank you for allowing us to share with you how telemedicine is transforming the landscape of healthcare delivery. My name is Dr. Christopher Haines, and I am the Chief Medical Officer at Children's Specialized Hospital, the largest pediatric rehabilitation system in the U.S. with 13 locations across New Jersey. Our medical team serves over 26,000 of the state's most medically complex pediatric patients including children with spinal cord injuries, brain injuries, chronic illness, autism, mental health and developmental delays. Our patients represent the top five percent of the sickest children in the state while using approximately 80 percent of the healthcare resources.

While our patients represent some of the most medically fragile population, resources are scarce as there is a national shortage of pediatric subspecialists. According to the American Academy of Pediatrics, there are roughly 28,000 pediatric specialists and over 80 million children in need of their care nationwide. In addition, the workforce of specialists is decreasing while the number of children in need of services is increasing at record rates; specifically children with autism, ADHD, depression, disabilities and obesity. This has led to an average wait time of three months for an appointment with many families traveling a great distance for care. This current landscape for pediatric patients is not conducive to high quality care and telemedicine is presenting an opportunity to achieve the triple AIM – better health, better care, lower cost.

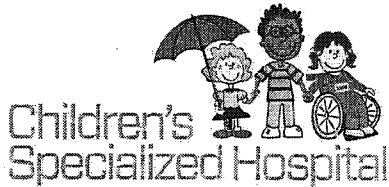
Through two pilot programs (Telemedicine Transition Home and telepsychiatry) we have identified critical needs that through the use of telemedicine technology can have a profound impact on thousands of children with complex medical needs by improving access to care, healthcare resource utilization, quality of care and patient satisfaction while reducing readmission rates.

We would like to highlight our Telemedicine Transition Home pilot program which was developed as a result of collaborating with the caregivers and parents of our most medically fragile patients. When patients were discharged from our inpatient hospital, parents were uneasy and wanted more communication with the medical team they relied on during their hospital stay. They needed additional support during this difficult transition period to home as well as to their general pediatrician.

This program allows physicians through the use of telemedicine technology to be virtually present and interact with the patient, family/caregiver. This was achieved by the deployment of a secure wireless, HIPAA compliant, telemedicine module with the family upon discharge for use in their home. As a result of the use of telemedicine technology, the Children's Specialized Hospital team has been able to both schedule and provide on-demand medical care and guidance that is not only convenient for the family, but serves as a quality bridge during this transitional period. We then are able to recover and reuse the telemedicine technology for future patients; furthering the reach and scope of benefit of this technology.

1-888-CHILDREN (244-5373) www.childrens-specialized.org

An affiliate member of the Robert Wood Johnson Health System and a member of Children's Miracle Network Hospitals.



In a little over a year, our team has utilized telemedicine with 46 of our most medically fragile patients with the following successful outcomes:

- Emergency department visits avoided - 31
 - Telemedicine enabled physicians to not only assess, but provide urgent interventions (eg: medication change, ventilator adjustment) that prevented emergency department utilization at an approximate cost of \$412* per visit
- Readmissions avoided
 - It is estimated based on published literature, that a significant percentage of these children would be readmitted to the hospital because of their medical complexity
 - The average cost of a pediatric inpatient stay is \$10,000*
 - Readmission rates are a major concern for the pediatric population, specifically medically complex children
 - Low readmission rates serve as an indicator for high quality of care
- Medical/Ambulance Transportation avoided
 - By providing this care at home using telemedicine; during this high risk period of transition from inpatient to outpatient medical care; there is a potential savings in medical transport of \$600-1,000 as these medically fragile patients are unable to travel via public transportation or private vehicle.
- Family/patient satisfaction
 - 100 percent of the families were highly satisfied with the use of telemedicine and care provided

Esteemed members of the committee, there are currently 43 states and the District of Columbia that provide some Medicaid reimbursement for telehealth services, and it is estimated there will be 8 million telemedicine patient encounters by 2018. We hope that we have demonstrated that telemedicine can not only provide cost effective, high quality healthcare; but it will also transform the way we provide access to healthcare for patients who need it most in New Jersey. There is much more we can do with increased support of and access to telemedicine solutions for the children, adults, and families in medical need across New Jersey.

Thank you.

Date: November 8, 2015

Dear Chairman and Members of the Committee:

My name is Judith Lane and I am the Director of Neuroscience at Robert Wood Johnson (RWJ), New Brunswick and Somerset Campuses. As part of my role, I am responsible for the Comprehensive Stroke Center at RWJ New Brunswick, which has sustained great success since its conception. Part of being a Comprehensive Stroke Center is demonstrating you have the staff and resources needed to take care of the most complex stroke patients while creating a collaborative approach and multidisciplinary team to see the patient through the continuum of care.

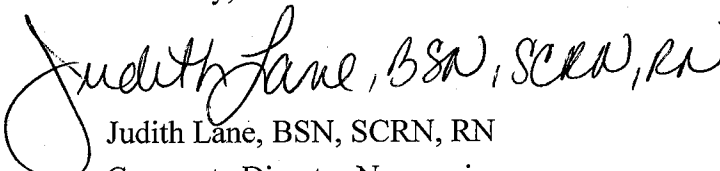
Stroke is the fifth cause of death in the United States and the leading cause of adult disability today. With the incidence of stroke projected to rise rapidly during the years ahead, enhancing stroke care has become an urgent priority for healthcare providers. In 2014, RWJ launched its first telemedicine service line, teleneurology/telestroke. This service is focused on reducing death and disability caused by stroke by partnering with community hospitals that lack 24 hour access to acute stroke experts and provide this expertise for them via two-way live video and audio consultations and image sharing technology. Community hospitals, and the patients they serve, will have access to academic medicine level care and protocols. By extending the regional presence of stroke centers, telestroke networks can facilitate improved stroke outcomes by increasing access to specialized care. It is also important to note that Sg2, a forecasting company, predicts a 20% decrease in the number of available neurologists to

care for this population, therefore making the need for telemedicine services more important in delivering specialized care to our communities and patients.

RWJ has the goal of elevating patient care across the region by implementing and developing telemedicine programs across numerous service lines. Many people have a difficult time accessing in-person healthcare due to mobility limitations, major distances or time barriers and transportation limitations. Telemedicine enables this population to receive critical and sometimes life-saving treatment regardless of economic means, physical ability, or residence. Remote patient monitoring is another example of how telemedicine can make a difference. It refers to managing a patient with a chronic condition in their home through virtual technology from the physicians or care management team's office/home. The clinicians have up to the minute access to the patient and their health information, consequently the patients have immediate access to the physician to help manage their condition and decrease readmissions into the acute care setting.

With looming physician shortages, coverage expansion and increasing consumer demand for convenient care, telemedicine is primed for future growth. It is stated that 70% of patients report being comfortable communicating with physicians via text, email or video and that by 2024 15% of all US evaluations and management visits will occur virtually. Telemedicine has a place today in how we deliver healthcare and I have personally witnessed how it saves and transforms lives. That type of experience is priceless and reminds us that the time is now to start planning for our futures.

Sincerely,


Judith Lane, BSN, SCRNP, RN
Corporate Director Neuroscience

Testimony before the Committee on Health, Human Services and Senior Citizens

November 9, 2015

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Chairman Vitale, members of the Committee on Health, Human Services and Senior Citizens, thank you for the invitation to provide testimony regarding the opportunities for broader integration of telehealth into healthcare for the citizens of New Jersey. My name is Dr. Karen Rheuban, and I direct the Center for Telehealth at the University of Virginia. I am the Principal Investigator of the federally funded Mid Atlantic Telehealth Resource Center, which provides technical assistance in telehealth across a broad range of Mid-Atlantic States, including New Jersey. I am also a past president of the American Telemedicine Association and Board Chair of the Virginia Telehealth Network. I have the privilege of serving as Board Chair of the Virginia Department of Medical Assistance Services (Medicaid). I recently joined the advisory board of Tytocare, a start-up telemedicine device company.

“Telemedicine” is defined as the practice of medicine using electronic communications, information technology or other means between a provider in one location, and a patient in another location. Generally, telemedicine is **not** an audio-only telephone conversation, e-mail/instant messaging conversation, or fax. Telemedicine is not a new specialty, a new procedure or a new clinical service but rather, technology



designed to enable the provision of healthcare services at a distance. 21st Century telemedicine services can be provided live, via high definition interactive videoconferencing supported by peripheral devices, or provided asynchronously, using store and forward technologies, or through the use of remote patient monitoring tools.

Telemedicine has been demonstrated to mitigate many of our nation's significant challenges including disparities in access to care, healthcare workforce shortages, and geographic mal-distribution of providers. Telemedicine improves patient triage, clinical outcomes, reduces the burden of travel for care, and fosters more timely access to care. Telemedicine tools support patient engagement and self-management where appropriate, and, as supported by extensive evidence published in the peer-reviewed literature, improves clinical outcomes, and lowers the cost of care.^{1, 2}

Vetted by and in collaboration with the relevant specialty societies, the American Telemedicine Association has developed and published practice guidelines designed to ensure best practices in telemedicine that ensure high quality care.

Examples of telehealth supported care include:

- Remote diagnosis of stroke with timely use of thrombolytic (clot busting) agents to reduce morbidity and mortality, improve patient outcomes, and lower overall costs of care;
- Delivery of telemedicine supported obstetrical services to women at high risk for complicated pregnancies ultimately resulting in improved clinical

¹ Lustig, Tracy A. The role of telehealth in an evolving health care environment: workshop summary. National Academies Press, 2012.

² Schwamm, Lee H., Heinrich J. Audebert, Pierre Amarenco, Neale R. Chumbler, Michael R. Frankel, Mary G. George, Philip B. Gorelick et al. "Recommendations for the Implementation of Telemedicine Within Stroke Systems of Care A Policy Statement From the American Heart Association." *Stroke* 40, no. 7 (2009): 2635-2660.

outcomes, lessened infant mortality rates, reduced days in neonatal intensive care and lower costs of care;

- Regular ophthalmologic screening of patients with diabetes for retinopathy, the number one cause of blindness in working adults;
- Better management of chronic illness such as heart failure, diabetes, hypertension, chronic obstructive pulmonary disease;
- Improved access to cancer screening tools, collaborative diagnosis through virtual tumor boards and even remote access to clinical trials;
- Access to mental health services for children and adults to include emergency psychiatry services;

Telemedicine supports an integrated systems approach focused on disease prevention, enhanced wellness, chronic disease management, decision support, improved efficiency, quality and patient safety.³

Opportunities for small practices to adopt telehealth relate to the role they wish to play. Primary care providers can serve as “originating sites” so as to connect their patients to specialists, they may offer direct-to-consumer services for their own patients, they may choose to serve on panels for telemedicine services companies offering direct-to-consumer services for their own patients or others, and/or they may engage in remote patient monitoring services for chronic disease management for their patients.

Specialty care providers may serve as consulting “distant site” providers to provide consultative services and follow up visits either through their offices or at the hospital.

Specialists may also serve as “originating sites” to connect to other providers. They may

³ Kvedar, Joseph, Molly Joel Coye, and Wendy Everett. "Connected health: A review of technologies and strategies to improve patient care with telemedicine and telehealth." *Health Affairs* 33, no. 2 (2014): 194-199.

offer services live using videoconferencing technologies or through store and forward applications. Specialty care providers may choose to serve on panels of consultants for telemedicine services companies, offer direct-to-consumer services for their patients or for payers and telemedicine services companies, and participate in remote patient monitoring models. Regardless of the model chosen, is imperative that willing providers take into consideration all relevant federal, state, specialty society policies and best practices that impact telehealth practice.

A) Rural healthcare:

Although rural communities face the same basic challenges in access, quality and cost as their urban counterparts, they do so at far greater rates, attributable to a host of factors. "Core health care services" as defined by the Institute of Medicine as primary care, emergency medical services, long term care, mental health and substance abuse services, oral health and other services are considerably less accessible in rural communities.⁴ Where local specialty care services are not available, particularly in rural and underserved regions and health professional shortage areas, telemedicine offers timely access to care and spares patients the burden of long distance travel for access to that care.

Rural communities lack sufficient patient volumes to support specialty and subspecialty practices. Primary care providers are often overwhelmed with complex patients with acute and chronic illness. Telehealth technologies offer ready access to critical services when rural providers partner with tertiary and quaternary care facilities.

⁴ Institute of Medicine, Committee on the Future of Rural Health Care. "Quality through collaboration: The future of rural health care." (2004).

Attracting health professionals to rural communities remains a daunting task and retaining those health professionals to practice in rural communities is all the more difficult. Rural healthcare providers generally work longer hours, see more patients and have greater on-call demands because of lack of cross coverage opportunities. Strategies to recruit and retain clinicians to practice in rural and frontier communities must include applications that enhance the management of patients with acute and chronic illness, and reduce the chronic sense of isolation experienced by those practitioners by affording enhanced connectivity to colleagues, and educational opportunities.

Telehealth should be viewed as integral to rural development. More than 90% of patients seen through our UVA telemedicine program remain within their community healthcare environment, resulting in a reduction of unnecessary transfers, and thereby contributes to the economic viability of community hospitals.

B) Urban healthcare

Although the challenges of unfavorable geography and distance tend to be uniquely rural, socioeconomic issues, health disparities, and other serious barriers to access to quality healthcare are *equally* compelling in urban areas. Poverty, unhealthy behaviors and adverse health status indicators are as prevalent in the shadow of our finest urban academic health centers as they are in rural communities. Isolated, vulnerable urban patients also suffer from high rates of chronic illness, and for whom a bus ride across town can be as challenging as is a long ride for a rural patient.

C) Workforce

It is widely accepted that our nation faces a shortage of physicians and other health professionals which is anticipated to worsen with our aging population, higher

rates of chronic illness, and greater numbers of covered individuals seeking care following the implementation of the Affordable Care Act. The Association of American Medical Colleges (AAMC) in a recent communication with the Committee on Veterans Affairs reported an estimated shortage of 46,000 primary care physicians and 45,000 specialists by 2020.⁵ The incorporation of telehealth technologies into integrated systems of care offers tools with great potential to address some of the challenges of access, specialty shortages, and changing patient needs both in the rural and urban setting.

D) Aging populations

The aging of our population has already created increased demand for specialty healthcare services to address both acute and chronic disease in the elderly. Such a demand, in the face of anticipated provider shortages, requires a fundamental shift from the model of physician centered care to one focused on patient centered care using interdisciplinary teams, evidence based medicine, the use of informatics in decision support and telehealth technologies when specialty care services are not locally available. Home telehealth and remote monitoring in the arena of chronic disease management improves care and prevents hospital readmissions.

To facilitate this paradigm shift, it is imperative that we train a broad spectrum of health professionals to deliver 21st Century healthcare facilitated by telehealth technologies.

E) Example: The University of Virginia Center for Telehealth

⁵<https://www.aamc.org/download/385178/data/aamclettertocongressionalconfereesonveteranaffairslegislation.pdf>

The UVA Telemedicine program serves as an example of both traditional and innovative applications in telehealth. Our Center for Telehealth was established initially as the Office of Telemedicine in 1996. Since the establishment of our program, we have developed collaborations and agreements connecting the UVA Health System with 155 partner sites across the Commonwealth using high definition video-teleconferencing, store and forward technologies, remote patient monitoring and mobile health applications to improve access to healthcare services for the citizens of the Commonwealth. We connect with hospitals, clinics, health centers, community service boards, medical practices, correctional facilities, skilled nursing facilities and emergency medical services and have supported more than 50,000 clinical encounters. Our telemedicine program has reduced the burden of travel for Virginians by more than 15 million miles, saved lives and fostered innovative models of care delivery and workforce development. UVA telemedicine supported clinical care spans the continuum from prenatal services, to acute care consultations and follow up visits, to chronic disease management and palliative care. We have launched a care-coordination and home based remote patient monitoring program designed to reduce hospital readmissions, and to manage chronic disease in the community setting. Over the past two years, that program has reduced hospital readmissions by nearly 40%, and improved clinical outcomes with extraordinary patient satisfaction data. We have leveraged these efforts to also expand broadband communications services in rural regions of the Commonwealth.

The UVA Telemedicine program has received funding from HRSA, USDA, the Department of Commerce, and the Rural Healthcare Support Mechanism of the Federal Communications Commission. We have worked with our colleagues at the Centers for



Medicare and Medicaid Services, and with the Institute of Medicine to help advance the implementation of policies that allow for innovation, sustainability and high quality patient care. In 2010, our Center for Telehealth was awarded a federal grant to serve as the Mid Atlantic Telehealth Resource Center (MATRC) to provide technical assistance to providers, healthcare systems, state governments and other entities in eight states and the District of Columbia, including much of New Jersey.

The Center for Telehealth has also worked closely with all relevant agencies of the Commonwealth of Virginia to help build our telemedicine network, to pilot innovative applications, and to ensure sustainability through sound state public policy collaborations that integrate telehealth into mainstream healthcare in the Commonwealth. These efforts led to broad reimbursement by Virginia Medicaid in 2003 and in 2010, a legislative mandate for parity third party payment, further refined in 2015.

Our Center for Telehealth tracks a host of metrics to include process metrics for emergency care (time from consult request to completion of encounter), process metrics for non-emergency services which are compared to traditional face to face services, clinical outcomes metrics, hospital readmissions rate, miles of travel avoided, comparisons to national benchmarked telemedicine programs, patient satisfaction, and other organizational metrics.

Examples of UVA telemedicine clinical outcomes metrics include:

- a) High-risk obstetrics telemedicine in which we compared traditional face to face care with care provided via telemedicine to 374 high risk pregnant women. We have documented a reduction in NICU hospital days for the infants born to these patients

by 39% compared to control patients, reduced patient no-shows by 62% and reduced patient travel by these pregnant women by 162,000 miles.⁶

- b) In partnership with BroadAxe Care Coordination, remote patient monitoring tools have been deployed to prevent hospital readmissions and have been an effective tool for patients with heart failure, acute myocardial infarction, chronic obstructive pulmonary disease, pneumonia, and joint replacement, reducing all cause 30 day readmissions by 40%.
- c) Store and forward ophthalmologic screening for retinopathy, the number one cause of blindness in working adults has been provided to urban and rural adults with diabetes. Our Medicaid programs do not meet their metrics of annual eye exams for diabetic patients. Over two years, 2093 patients have been screened in community clinic settings. Not surprisingly, 39% were found to have retinal abnormalities and 80 requiring intervention to prevent blindness.
- d) Remote patient monitoring tools have been used to reduce the burden of diabetes in the community setting. All clinical metrics tracked (Hgb A1c, fasting blood sugar and blood pressure) have had impressive reductions in the range of 9-10% within a six month period.
- e) More than 2000 patients have participated in the video-based interactive patient education programs offered by our diabetes community network.

F) Issues for consideration:

⁶ Veith, Sharon T et al, "Perinatologists and Advanced Practice Nurses Collaborate to Provide High Risk Prenatal Care in Rural Virginia Communities." In *Association of Women's Health, Obstetric and Neonatal Nurses (June 14-18, 2014)*. AWHONN, 2014.

Despite the federal government and private industry's multi-billion dollar investment in telemedicine, broadband expansion and health information technologies, disappointingly, efforts to promulgate continued integration of telemedicine remain stifled by 20th Century federal and state barriers to more widespread adoption. If challenging to large healthcare systems such as ours, it follows naturally that despite great promise, these obstacles create significant challenges for small medical practices seeking to use telehealth tools. Larger systems can draw upon the expertise of contract attorneys, information technology specialists, a robust billing staff, electronic medical records and picture archiving and communications services, credentialing and privileging staff, and other support systems to help facilitate telehealth integration.

Currently, 26 different federal agencies report engagement in telehealth, be it through research or other grant funding opportunities, the establishment of broadband communications networks, clinical service delivery, device development and regulation, and other interests. The Fed-Tel working group efforts to coordinate telehealth policy has made some progress, however, there still remains a serious lack of coordination of practical policies across these agencies in part because of statutory barriers.⁷

As an example: mal-aligned federal definitions of rural have resulted in federal grant support for telemedicine technology and broadband connectivity deployed to certain clinics and hospitals eligible for funding according to those agency definitions of rural, but sustainability is thwarted by statutory barriers that deny Medicare reimbursement because of a more limited Medicare definition of rural and other

⁷ Doarn, Charles R., Sherilyn Pruitt, Jessica Jacobs, Yael Harris, David M. Bott, William Riley, Christopher Lamer, and Anthony L. Oliver. "Federal Efforts to Define and Advance Telehealth—A Work in Progress." *Telemedicine and e-Health* 20, no. 5 (2014): 409-418.

originating site restrictions. Inconsistent state policies and regulations create additional barriers for otherwise willing providers seeking to integrate telehealth into care delivery models.

1) Reimbursement

a) Medicare:

Payment coverage restrictions remain a major impediment to the broader adoption of telehealth by providers. Congress, in 1997, through the Balanced Budget Amendment, and in 2000, through the Benefits Improvement and Protection Act (BIPA), authorized the Center for Medicare and Medicaid Services (CMS) to reimburse for telehealth services provided to rural Medicare beneficiaries across a broad range of CPT codes and services. However, the current Medicare telehealth provisions in the Social Security Act 1834(m), enacted in 2000, have not kept pace with advancements in technology, and more than a decade of best practices and outcomes research. In the Act, Congress, directed CMS to study and report opportunities to expand coverage within two years. Fourteen years later, no such report has been produced.⁸

The Affordable Care Act did not expand eligible originating sites in the traditional Medicare program in part because of adverse scoring by the Congressional Budget Office that failed to take into account services provided in lieu of face to face care, and Medicare savings accrued by patient monitoring programs and fear of overutilization. Pilot programs have been launched through the Center for Medicare and Medicaid Innovation that include remote patient monitoring. The regulations for Accountable Care Organizations still require the patient originating site to conform to the regulations

⁸ Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) section 223(d)

set forth in Section 1834 (m) without flexibility to include providers serving patients living in metropolitan communities across the nation including patients in nursing homes.⁹ These statutory barriers placed on telehealth programs are borne out by the meager reimbursements reported by CMS for telemedicine services. **In 2014, CMS reported fewer than \$14 million dollars in reimbursements for “allowable charges” NATIONWIDE which include distant site and originating site fees.** Although physician offices and community based clinics are ideal originating sites for telemedicine encounters, the current Medicare originating site payment (\$24.63) is insufficient to cover the costs of establishing and maintaining a telemedicine service. In its 2014 physician payment schedule, CMS expanded its operating definition of rural from non-metro counties only to also include those regions defined as rural by the Office of Rural Health Policy.

b) Medicaid:

Currently 47 state Medicaid programs provide **some** form of reimbursement for the delivery of telehealth facilitated care to Medicaid beneficiaries. However, there is no consistency in telehealth coverage across the Medicaid programs, despite clear needs of patients served by our Medicaid programs and in the face of coverage expansion post implementation of the Affordable Care Act . Most Medicaid programs pay for transportation of patients and yet, in many states, there are still considerable limitations on coverage for telehealth services. In 2013, Virginia Medicaid expended \$70 million dollars on non-emergency transport of Medicaid beneficiaries.¹⁰ A consistent federal-state approach to Medicaid payment for telehealth services would provide cost-savings

⁹ Grabowski, David C., and A. James O'Malley. "Use of telemedicine can reduce hospitalizations of nursing home residents and generate savings for medicare." *Health Affairs* 33, no. 2 (2014): 244-250.

¹⁰ Communication with Hazelton, A., Virginia Department of Medical Assistance Services, July 2014

both in operations costs (transportation) and more importantly, in access to care and models of care delivery. Virginia Medicaid has taken many positive steps integrating telehealth for its beneficiaries, and since 2003, has provided telehealth coverage for urban and rural beneficiaries. Virginia Medicaid covers live-interactive video based consultations and follow-up care for all Medicaid enrollees. Our Medicaid program has begun to cover certain store-forward services by Medicaid providers, and has integrated remote patient monitoring for our (urban and rural) dual enrollees, the most vulnerable and costly patients we serve, through our newly launched pilot with CMS “Commonwealth Coordinated Care”. Virginia Medicaid has also expanded the list of eligible providers and services beyond the eligible providers in Medicare. Medicaid coverage decisions requested by providers are analyzed based on clinical need, technical viability of the service, models supported by other payers, support of professional organizations, establishment of protocols, costs, and risk of fraud and abuse. In 2013, Virginia Medicaid reported reimbursements of \$570,000 for more than 10,000 telemedicine claims in the fee for service and managed care programs.¹¹ In 2015, Virginia Medicaid began a year-long process to apply for a DSRIP (Delivery System Reform Incentive Payment Program) waiver from CMS to modernize our Medicaid program, which further weaves telehealth into models of care coordination and delivery.

c) Private pay:

Twenty-nine states including the District of Columbia currently require that private insurance cover telehealth services. Some of the commercial payers support payment for telemedicine services even in the absence of a state mandate. Others have

¹¹ Communication: Nelson, J, Virginia Department of Medical Assistance Services, July 2014

developed or adopted direct-to-consumer models as either a benefit to members, or an additional payment option.

d) Other models:

A number of telemedicine services companies have developed models to provide contractual services to hospitals, correctional facilities and other entities, by recruiting individual physician providers and contractually fully managing the interface between physician, hospital and patient (examples: *Specialists on Call*®, *Insight Telepsychiatry*®). Other companies contract with payers or directly with patients in the direct to consumer model (examples: *Teladoc*®, *American Well*®, *MD Live*®) and offer services via video-based encounters and telephone services to the home, workplace or travel locations. The Federation of State Medical Boards¹² and the American Medical Association¹³ have issued recent policy documents and guiding principles to ensure patient safety, quality of care, privacy of patient information, protecting the patient-physician relationship while promoting improved care coordination and communication within medical homes.

2. Boards of Medicine policies:

Inconsistent board regulations across the states and territories have led to continued confusion for practitioners. Some state boards have adopted positions of opposition to the mainstream adoption of telehealth requiring an in-person visit prior to any subsequent telehealth encounters. We **applaud** the Federation of State Medical Boards, for its April, 2014 Report *Appropriate Regulation of Telemedicine (SMART)*

¹² http://www.fsmb.org/Media/Default/PDF/FSMB/Advocacy/FSMB_Telemedicine_Policy.pdf

¹³ REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-14) Coverage of and Payment for Telemedicine, June, 2014

Workgroup report. This report, “*Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*” establishes a framework and common language for adoption by the states.¹² As stated by the FSMB, “this new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.” Notably, this working group provided guidance to the Boards of Medicine that an initial telemedicine encounter (live interactive video based or store and forward) can indeed establish a bona-fide doctor patient relationship so long as the encounter conforms to current standards of practice. Indeed, our experience and that of others supports that concept. Timely access to care is a key driver of telemedicine programsas an example, it is highly unlikely that any acute stroke victim might pre-emptively have scheduled an in person visit with a stroke neurologist prior to suffering his/her first stroke. We rely upon our clinicians and their respective specialty societies to determine the wisdom and need for an initial in-person visit when developing our telehealth protocols.

The SMART Working group also established additional guidelines for the Boards that address informed consent, privacy and security of patient records, patient choice, prescribing, licensure, continuity of care and access to emergency care. In particular, the FSMB model policy clearly states that prescribing as a result of a telemedicine encounter

should follow all current standards of practice in terms of indications, appropriateness and safety considerations.

3. Credentialing and Privileging

Credentialing and privileging are important elements of telehealth practice so as to ensure patient safety, quality and that appropriate services are provided by the appropriately credentialed provider. Telehealth has been incorporated into the Joint Commission standards beginning in 2000 and in their revised standards of 2004. In 2011, after extensive deliberations with telehealth providers, CMS published much welcomed new regulations in its hospital Conditions of Participation standards to address credentialing and privileging to include proxy arrangements so as to further facilitate the delivery of telemedicine services across the nation.¹⁴ Despite this progress, there remain delays in the credentialing and privileging processes, and confusion amongst practitioners and hospitals regarding roles and responsibilities to include the requisite sharing of quality data.

4. Licensure

State medical licensure is a slow, costly and cumbersome process for providers who wish to offer services through telemedicine to patients physically located in other states. The process of securing multiple licenses is time consuming at its best, with requirements for extensive primary source verification, an application and fee for licensure in the states in which the provider might wish to evaluate and treat patients. So as to ensure the ability of the Boards to respond to complaints and enforce actions against providers, in response to requests for licensure portability, in April, 2014, the Federation of State Medical Boards (FSMB) developed an expedited licensure

¹⁴ http://www.ofr.gov/OFRUpload/OFRData/2011-10875_PI.pdf.

process. As compared to true licensure portability, as has been applied in the Nurse Compacts and as proposed in legislative proposals, this new process still risks being time consuming and costly to providers. Nonetheless, the FSMB expedited licensure process is an improvement over current licensure policy and has been adopted by many states.

5. Stark and Anti-kickback laws

Providers and healthcare systems must be aware of the implications of the Stark and Anti-kickback laws when considering models for acquisition of telehealth equipment and technology. As reported on the CMS website, “the Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program.¹⁵ Where remuneration is paid, received, offered, or solicited purposefully to induce or reward referrals of items or services payable by a Federal health care program, the Anti-Kickback Statute is violated.

The Physician Self-Referral Law (Stark Law) (42 U.S.C. Section 1395nn) prohibits a physician from making a referral for certain designated health services to an entity in which the physician (or an immediate member of his or her family) has an ownership/investment interest or with which he or she has a compensation arrangement, unless an exception applies.”

Both these statutes must be considered as important risks for telemedicine providers or entities who “purchase, lease, order, or arrange for or recommend the purchasing, leasing, or ordering of any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program.....Health care providers must take utmost precaution and care in developing processes and procedures

¹⁵ https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Fraud_and_Abuse.pdf

to implement telemedicine programs to avoid liability under the Stark and Anti-Kickback statutes".¹⁶

6. Broadband availability:

The Rural Healthcare Program of the Federal Communications Commission's Universal Service Fund was established following the passage of the Telecommunications Act of 1996. This program has been extraordinarily useful in expanding broadband services for eligible entities located in rural areas by providing discounts for ongoing connectivity that compare to those rates available to urban providers. Unfortunately as compared to the e-Rate, High Cost, and Low Income programs, the Rural Healthcare Programs have not fully met their Commission defined funding cap because of onerous, complex application processes, and statutory exclusions to eligibility that do not always align with health disparities. In the Telecommunications Program, as an example, for profit hospitals, initially considered ineligible entities, may receive funding support for connectivity to the Emergency Department but other connections within that hospital are not eligible, even if that hospital is the sole provider in a rural county.¹⁷

Other ineligible entities include emergency medical services providers and skilled nursing facilities. For-profit clinics and solo practices are not eligible for support. Good faith efforts by the FCC to expand within their statutory authority, has led to somewhat broader use of the Telecommunications Program. The FCC Pilot Program and the Health Care Connect Fund, allows, through consortia, collaborations that may

¹⁶ Ali, S. <http://ctel.org/wp-content/uploads/2011/12/CTeL-The-Practice-of-Telemedicine-The-Impact-of-Stark-and-Anti-Kickback.pdf>

¹⁷ *FCC Report and Order, Order on Reconsideration and further Notice of Proposed Rule Making*, Federal Register: January 22, 2004 Volume 69, Number 14

include urban providers. Chapter 10, *Healthcare*, of the National Broadband Plan, outlined important steps to integrate broadband communications services into sustainable models of healthcare delivery.¹⁸

Despite significant outreach efforts, utilization of the fund still remains less than 50% of the funding cap established by the Commission after passage of the Telecommunications Act of 1996. Total funding commitments reported on the Rural Healthcare website through June 2012 were \$114,123,355 of which \$47,723,468.67 were allocated to providers in Alaska.¹⁹

The cumbersome and time consuming application process and confusing regulations surrounding the rural healthcare programs remain a disincentive for participation by individual providers and small practices even if they otherwise meet the eligibility requirements set forth in the Act.

7. Patient Privacy and Disclosure

Providers must ensure that any telemedicine collaboration conform fully to the regulations of the Health Insurance Portability and Accountability Act (HIPAA). As with in-person healthcare, providers have a duty to maintain confidentiality and security of patient data. Where a technical staff is included in the healthcare team at both originating and distant sites, and with the additional components of technologies and communications service providers, it is imperative that providers pay special attention and adhere to both the privacy and security elements of the HIPAA regulations. The HIPAA Omnibus Rule requires that providers and their healthcare associates have in

¹⁸ Thomes, Cynthia. "The National Broadband Plan: Connecting America. Administered by the Federal Communications Commission, 445 12th Street SW, Washington, DC 20554. Retrieved October 15, 2010, from <http://www.broadband.gov>." (2011): 435-436.

¹⁹ <http://www.usac.org/rhc/tools/news/default.aspx?pgm=telecom>

place a Business Associate Agreement (BAA) when interactions include protected health information. Business associates include entities that create, receive, maintain, or transmit protected health information to perform certain functions on behalf of a covered entity. They also include subcontractors of the business associate delegated a function, activity, or service in a capacity other than as a member of the business associate's workforce. HIPAA also requires the covered entity be able to conduct audit trails to ascertain the presence of breaches which is not readily available with certain video based applications. As an example, in 2011, Skype issued the following statement:

*"Skype is not a business associate subject to HIPAA, nor have we entered into any contractual arrangements with covered entities to create HIPAA-compliant privacy and security obligations. Instead, Skype is merely a conduit for transporting information, much like the electronic equivalent of the US Postal Service or a private courier. Skype does not use or access the protected health information (PHI) transmitted using our software. However, Skype has implemented a variety of physical, technical and administrative safeguards (including encryption techniques) aimed at protecting the confidentiality and security of the PHI that may be transmitted using Skype's calling and video calling products."*²⁰

Many practitioners are unaware of the complex nuances of these regulations as they relate to telemedicine and do not have in place the legal infrastructure to assist them in managing the additional regulations that govern telehealth practice.²¹

²⁰ Skype Statement: onlinetherapyinstitute.com/2011/03/videoconferencing-secure-encrypted-hipaa-compliant/

²¹ <http://caltrc.org/wp-content/uploads/2014/01/HIPAA-for-TRCs-2014.pdf>

8. Informed consent

Informed consent is a requisite element of all healthcare encounters. Telehealth practice adds additional layers of disclosure, to include authentication of the identity and location of the patient and provider, provider credentials, and delivery systems utilized during the encounter. In addition, providers must have in place an emergency plan should the clinical situation warrant a higher level of care, and a plan for care in the event of technology failure and all should be disclosed to the patient as a component of the consent.

The FSMB Model Policy makes the following recommendations regarding Informed Consent.¹²

“Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician’s credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.”

9. Standards and Practice Guidelines:

The American Telemedicine Association and its >3000 member supported Special Interest Groups, Committees and Discussion groups have developed standards to address technical applications, and clinical practice guidelines, many of which have been endorsed by specialty societies.²² Many of the specialty societies have independently developed similar guidelines.

These standards and practice guidelines extend beyond the practice guidelines that currently exist for traditional healthcare. The development of standards and guidelines, addressing both interoperability (such as HL7, DICOM, or H.320, 323, 324, compression standards for videoconferencing) and specialty specific applications (such as teleophthalmology or telepathology), will increase functionality related to and acceptance of advanced technologies applied to healthcare. The Special Interest Groups of the American Telemedicine Association have worked collaboratively with the clinical specialty societies to develop practice guidelines in telehealth that conform to accepted standards of care. These guidelines are developed after careful review of the evidence, and in consultation with the specialty societies. Examples include teleophthalmology, teledermatology, telemental health, tele-ICU, home telehealth, telerehabilitation, and telepathology. Practice guidelines and standards guide providers and payers in models of best practice, informed by the evidence.

10. Provider education, technical support and training

¹² FSMB

²² Krupinski, Elizabeth A., and Jordana Bernard. "Standards and Guidelines in Telemedicine and Telehealth." In *Healthcare*, vol. 2, no. 1, pp. 74-93. Multidisciplinary Digital Publishing Institute, 2014.

Training programs in telehealth are important additional elements of health professional education and include the appropriate use of telehealth technologies, board regulations, relevant standards and guidelines, interprofessional models of practice enhanced by telehealth, and specific training to operate and troubleshoot videoteleconferencing equipment, devices and patient monitoring tools. The American Telemedicine Association offers certification for certain for-credit programs, and others have developed hybrid on-line and hands on training. With HRSA funding, and in partnership with the Virginia Health Workforce Development Authority we have trained 800 licensed health professionals across the disciplines to become certified telehealth presenters, and/or coordinators to keep pace with the demand for such trainees. Telehealth should be incorporated into every medical and nursing school curriculum, with subsequent experiences during graduate medical education so as to prepare our physicians and nurses on the appropriate use of telehealth in everyday practice.

11. The evidence:

In 2013, the American Telemedicine Association reported “Over 40 years of research has yielded a wealth of data about the cost effectiveness and efficacy of many telemedicine applications.”²³

More than 20,000 citations in the peer reviewed literature address outcomes across the specialties, including pediatric cardiology, high risk pregnancies, congestive heart failure, asthma, chronic obstructive pulmonary disease, cancer, telepathology, teleradiology, diabetes care, dermatology and wound care, to name just a few. The

²³ <http://www.americantelemed.org/docs/default-source/policy/examples-of-research-outcomes---telemedicine's-impact-on-healthcare-cost-and-quality.pdf>

overwhelming evidence is that telemedicine and remote patient monitoring compares favorably with in person care, and in many cases, is associated with better outcomes.

a. Home telehealth

Home telehealth is defined as the use of synchronous or asynchronous telecommunications technologies by a home care provider to link patients to out-of-home sources of medical care, education, or other services. These services may incorporate interactive home telehealth technologies using POTS (plain old telephone service) or broadband telecommunications technologies. Home telehealth programs generally include monitoring devices such as pulse oximetry, blood pressure, EKG, blood sugar, weight, temperature, and passive monitoring of motion. It has been reported by the Food and Drug Administration, which regulates medical devices, that home care systems represent the fastest growing segment of the medical device industry.

Home telehealth can be utilized by traditional home health agencies, for the delivery of hospice care, or for case management by providers, clinics or hospitals to facilitate chronic disease management for patients. Home telehealth programs reduce readmission rates, visits to the emergency room, physician visits, and impart significant cost savings. The federal government supports major initiatives for aging in place such as PACE, but does not cover the technologies that will keep people healthy, and independent in their own homes.

The Veteran's Administration has published data to demonstrate that the VA Care Coordination and Home Telehealth program reduces hospital admissions by 19% and hospital days by 25% for patients with chronic disease.²⁴

²⁴ Darkins, Adam, Patricia Ryan, Rita Kobb, Linda Foster, Ellen Edmonson, Bonnie Wakefield, and Anne E. Lancaster. "Care coordination/home telehealth: the systematic implementation of health informatics,

Integration of home telehealth into rural models of healthcare is a particularly efficient cost-effective choice when one considers the distances traveled by home health staff in rural areas. Factoring in the time spent traveling to the home, significant cost savings accrues with the use of these technologies. Dimmock et al report the cost savings associated with the supplementation of regular in home visits by home telehealth visits at approximately \$50/visit.²⁵

A recent analysis of the evidence for telemedicine interventions to include remote patient monitoring has identified significant cost-savings and improved outcomes when applied to the management of chronic illness.²⁶ These findings are consistent with our earlier referenced UVA Center for Telehealth experience.

12. Acceptance of advanced technologies

Patient acceptance of and satisfaction with the use of telehealth technologies for consultation and ongoing acute and chronic care has been remarkably positive, attributable in part to the obvious benefit of timely access to locally unavailable specialty healthcare that spares patients the burden and expense of travel to remote tertiary and quaternary healthcare facilities. Indeed, we have collected data in many of our programs that demonstrates the telehealth “no-show” rate is considerably lower than the in-person clinic “no show” rate.⁶

home telehealth, and disease management to support the care of veteran patients with chronic conditions." *Telemedicine and e-Health* 14, no. 10 (2008): 1118-1126.

²⁵ Dimmock, S et al, A case study of benefits and potential savings in rural home telemedicine, *Home Healthcare Nurse*, 2000:18 (2) 124-135.

⁶ Veith, Sharon T et al

²⁶ Bashshur, Rashid L., et al. "The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management." *Telemedicine and e-Health*(2014).

Provider acceptance of advanced technologies and telehealth tools has been equally gratifying for patient consultation, patient education, distance learning opportunities, and for collaborations in remote patient monitoring.

13. Direct-to-consumer telemedicine:

Consumer demand for convenient access to healthcare services in the digital era, in part fueled by enrollment high deductible health plans, has resulted in a paradigm shift in urgent care-primary care delivery models. Direct-to-consumer telemedicine models have proliferated supported by patients, providers, health plans, entrepreneurs and investors. These virtual care delivery models, (using appropriately licensed providers) made available in the home, mobile or workforce settings have been reported to enhance access, reduce emergency room visits, and lower the cost of care, but have also been criticized for risking fragmentation of care, overprescribing of antibiotics, and providing services that do not comport to the standard of care of in-person settings. The opportunity to use video based or store and forward services integrated with high quality peripheral devices and home based testing designed to replicate the in-person visit, may mitigate some but not all of those concerns. Such tools and platforms, informed by the evidence, are particularly appealing within the context of the medical home.²⁷

Conclusion:

Telehealth is an essential tool to address the significant challenges of access to high quality care for both acute and chronic disease management, to mitigate workforce shortages, improve population health and lower cost of care. There are many opportunities for small practices to integrate telehealth models into every-day practice.

²⁷ L Uscher-Pines, A Mulcahy, D Cowling, G Hunter and Mehotra, A; Telemedicine and e-Health, 2015 Access and Quality of Care in Direct-to-Consumer Telemedicine



However, even for large healthcare systems, managing and navigating the complex legal and regulatory environment which impacts the practice of healthcare using telehealth tools can be challenging. For small group practices and solo practitioners, telehealth holds great promise, but the administrative and regulatory challenges can be overwhelming. Thus it is imperative that we create and promulgate policies that foster certainty, transparency, high quality, secure and sustainable solutions that empower patients, providers and payers to adopt 21st Century models of care.

Appendix A



**Medicare Reimbursement for Telehealth Services through
The Centers for Medicare & Medicaid Services**

Calendar Years 2001-2014

Medicare Telehealth Services				
Year	Distant Site		Originating Site	
	Allowed Services	Allowed Charges	Allowed Services	Allowed Charges
2001	1,494	\$ 55,422	294	\$ 5,880
2002	5,285	\$ 185,086	1,596	\$ 31,836
2003	6,776	\$ 404,764	4,389	\$ 90,186
2004	11,266	\$ 765,179	7,841	\$ 161,880
2005	15,970	\$ 1,176,329	10,972	\$ 227,349
2006	25,461	\$ 2,124,881	15,908	\$ 333,138
2007	25,395	\$ 1,991,753	14,336	\$ 310,296
2008	23,144	\$ 1,613,408	9,247	\$ 208,964
2009	37,503	\$ 2,797,893	17,100	\$ 393,291
2010	46,655	\$ 3,397,285	23,660	\$ 550,171
2011	82,701	\$ 5,938,090	32,450	\$ 761,230
2012	106,023	\$ 7,467,157	38,540	\$ 903,233
2013	136,429	\$ 10,689,862	46,147	\$ 1,112,446
2014	155,387	\$ 12,482,270	58,959	\$ 1,452,160

Please note that the "allowed charges" represent the amount paid by both Medicare and the beneficiary (including beneficiary deductible and co-insurance).

Here are some additional things to consider when examining the numbers above:

- This data only reflects services paid under the Medicare Telehealth benefit, which only includes services otherwise furnished in-person and would not include professional interpretations of diagnostic tests, for example, that are not subject to Medicare telehealth rules. These services are often referred to as "Telehealth," but are not included in this data.
- The distant site bills for the specific service furnished by reporting the same CPT or HCPCS code(s) reported when the service is furnished in-person. The originating site, by statute, can only bill for the originating site facility fee, which is a national flat fee that is updated annually. The originating site will report only one originating site facility fee, per encounter, even if the distant site practitioner furnishes more than one reportable telehealth service during the same encounter.
- The data relies on the distant site practitioner correctly applying the telehealth modifiers to claims.

Information Provided by Centers for Medicare & Medicaid Services—May, 2015

Testimony before the Committee on Health, Human Services and Senior Citizens**November 9, 2015**

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Chairman Vitale, members of the Committee on Health, Human Services and Senior Citizens, I too want to thank you for the invitation to provide testimony regarding the opportunities for broader integration of telehealth into healthcare for the citizens of New Jersey. My name is Kathy Wibberly, and I am Director of the Mid-Atlantic Telehealth Resource Center housed at the University of Virginia. Telehealth Resource Centers or TRCs are funded by the US DHHS Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth, which is part of the Federal Office of Rural Health Policy. TRCs support telehealth program development and sustainability and its services are available at NO COST to those wishing to use electronic information and telecommunications technologies to support clinical health care, health-related education, public health and health administration at a distance.

The first small group of TRCs was funded in 2006. The success experienced by these programs as well as the increasing interest in telehealth, supported the slow expansion of the TRC program. As of 2012, nationally, there are 14 TRCs; 12 Regional Centers whose combined coverage reaches all 50 states and the Pacific Islands and two National Centers which focus on areas of technology assessment and telehealth policy. TRCs work collaboratively and participate in a consortium known as the National

Consortium of TRCs. Our regional center (MATRC) partners with the Northeast TRC to ensure that all citizens of New Jersey have access to TRC support.

TRCs offer the following types of services:

- A central website that houses key resources and tools for telehealth program development.
- Monthly national webinars featuring key topics areas presented by telehealth leaders from around the country (all of which are recorded and archived so that they may be viewed at any time)
- Policy analysis and technology assessments.
- Access to the nation's best telehealth experts.
- Specialized tools and templates.
- Training for the telehealth workforce.
- Educational materials, including best practices, standards and guidelines.
- State, regional and local strategic planning and plan development.

Telehealth has been in existence for well over 20 years. It had its roots in rural health because it provided a solution to many rural health challenges, as noted by Dr. Rheuban. The beginnings of telehealth were primarily a traditional hub and spoke model, where small rural and community hospitals (called spokes) connected to a larger, typically urban tertiary care center (called the hub). The beginnings were very rough. Prices were high, bandwidth was low, and best practices had not yet been developed. In spite of that, we saw some incredible rural successes.

However, as time passed, technology improved, bandwidth increases, and costs went down. Health professionals began to realize that telehealth was not just for rural

specialty care but had many applications that could address some of the most pressing challenges for healthcare delivery systems, whether rural, urban or suburban. These included chronic disease management, fragmented and compartmentalized services, the aging of the population, and the cost of care. The past decade we have seen telehealth start to play a significant role in the Patient Centered Medical Home, for allowing people to age in place, for facilitating better safety and quality, for care coordination and integration, and for enhanced access and continuity of care. As a result, over the past decade, we have witnessed the move from a traditional hub and spoke model to one that has become a network of networks. Networks where primary care providers and community based facilities and clinics are all interconnected with each other, with hospitals, with emergency rooms, with emergency medical services and with specialty care practices.

Today we are on the precipice of another major paradigm shift in telehealth. The concept of Care Anywhere is rapidly coming to fruition. Instead of patients having to go to a particular facility to receive care, telehealth is enabling care to go wherever the patient is, to include places like the patients home, school, and workplace. There is a recently published book whose title "The Patient Will See You Now" captures the emerging future of healthcare. The future of telehealth is to make the possibility of right care, in the right place, at the right time a reality.

Although telehealth has been around for decades, it has not yet achieved its full potential. Telehealth is not about technology, but about the people (workforce and workforce training), processes (protocols, procedures, business models) and policies (laws, regulations) that all need to come into full alignment. As Dr. Rheuban so

eloquently stated, it is imperative that we create and promulgate policies that foster certainty, transparency, high quality, secure and sustainable solutions that empower patients, providers and payers to adopt 21st Century models of care. We are living in a time of rapid advances in technology. We need to take care to ensure that any policies we put into place are nimble so that these policies do not ultimately become an impediment that keeps us from using the tools that are at our disposal for improving the patient experience of care, improving the health of populations and reducing the per capita cost of health care.

VIRGINIA ACTS OF ASSEMBLY -- 2010 SESSION

CHAPTER 222

An Act to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.16, relating to health insurance coverage for telemedicine services.

[S 675]

Approved April 7, 2010

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.16 as follows:

§ 38.2-3418.16. Coverage for telemedicine services.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section.

B. As used in this section, "telemedicine services," as it pertains to the delivery of health care services, means the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. "Telemedicine services" do not include an audio-only telephone, electronic mail message, or facsimile transmission.

C. An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services.

D. An insurer, corporation, or health maintenance organization shall not be required to reimburse the treating provider or the consulting provider for technical fees or costs for the provision of telemedicine services; however, such insurer, corporation, or health maintenance organization shall reimburse the treating provider or the consulting provider for the diagnosis, consultation, or treatment of the insured delivered through telemedicine services on the same basis that the insurer, corporation, or health maintenance organization is responsible for coverage for the provision of the same service through face-to-face consultation or contact.

E. Nothing shall preclude the insurer, corporation, or health maintenance organization from undertaking utilization review to determine the appropriateness of telemedicine services, provided that such appropriateness is made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by such policy, contract, or plan. Any such utilization review shall not require pre-authorization of emergent telemedicine services.

F. An insurer, corporation, or health maintenance organization may offer a health plan containing a deductible, copayment, or coinsurance requirement for a health care service provided through telemedicine services, provided that the deductible, copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance applicable if the same services were provided through face-to-face diagnosis, consultation, or treatment.

G. No insurer, corporation, or health maintenance organization shall impose any annual or lifetime dollar maximum on coverage for telemedicine services other than an annual or lifetime dollar maximum that applies in the aggregate to all items and services covered under the policy, or impose upon any person receiving benefits pursuant to this section any copayment, coinsurance, or deductible amounts, or any policy year, calendar year, lifetime, or other durational benefit limitation or maximum for benefits or services, that is not equally imposed upon all terms and services covered under the policy, contract, or plan.

H. The requirements of this section shall apply to all insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and after January 1, 2011, or at any time thereafter when any term of the policy, contract, or plan is changed or any premium adjustment is made.

I. This section shall not apply to short-term travel, accident-only, limited or specified disease, or individual conversion policies or contracts, nor to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this

chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1306.1, § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.16, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.15, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541.1, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, § 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6 and 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions 1, 2, and 3 of subsection F of § 38.2-3407.10, 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, and 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and § 38.2-5903 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B of this section shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

40 maintenance organization is responsible for coverage for the provision of the same
41 service through face-to-face consultation or contact.

42 E. Nothing shall preclude the insurer, corporation, or health maintenance organization
43 from undertaking utilization review to determine the appropriateness of telemedicine
44 services, provided that such appropriateness is made in the same manner as those
45 determinations are made for the treatment of any other illness, condition, or disorder
46 covered by such policy, contract, or plan. Any such utilization review shall not require
47 pre-authorization of emergent telemedicine services.

48 F. An insurer, corporation, or health maintenance organization may offer a health plan
49 containing a deductible, copayment, or coinsurance requirement for a health care
50 service provided through telemedicine services, provided that the deductible,
51 copayment, or coinsurance does not exceed the deductible, copayment, or coinsurance
52 applicable if the same services were provided through face-to-face diagnosis,
53 consultation, or treatment.

54 G. No insurer, corporation, or health maintenance organization shall impose any annual
55 or lifetime dollar maximum on coverage for telemedicine services other than an annual
56 or lifetime dollar maximum that applies in the aggregate to all items and services
57 covered under the policy, or impose upon any person receiving benefits pursuant to this
58 section any copayment, coinsurance, or deductible amounts, or any policy year,
59 calendar year, lifetime, or other durational benefit limitation or maximum for benefits or
60 services, that is not equally imposed upon all terms and services covered under the
61 policy, contract, or plan.

62 H. The requirements of this section shall apply to all insurance policies, contracts, and
63 plans delivered, issued for delivery, reissued, or extended in the Commonwealth on and
64 after January 1, 2011, or at any time thereafter when any term of the policy, contract, or
65 plan is changed or any premium adjustment is made.

66 I. This section shall not apply to short-term travel, accident-only, or limited or specified
67 disease policies or contracts, nor to policies or contracts designed for issuance to
68 persons eligible for coverage under Title XVIII of the Social Security Act, known as
69 Medicare, or any other similar coverage under state or federal governmental plans.

70 § 54.1-3303. Prescriptions to be issued and drugs to be dispensed for medical or
71 therapeutic purposes only.

72 A. A prescription for a controlled substance may be issued only by a practitioner of
73 medicine, osteopathy, podiatry, dentistry or veterinary medicine who is authorized to
74 prescribe controlled substances, or by a licensed nurse practitioner pursuant to § 54.1-
75 2957.01, a licensed physician assistant pursuant to § 54.1-2952.1, or a TPA-certified
76 optometrist pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32. The prescription
77 shall be issued for a medicinal or therapeutic purpose and may be issued only to

78 persons or animals with whom the practitioner has a bona fide practitioner-patient
79 relationship.

80 For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is
81 one in which a practitioner prescribes, and a pharmacist dispenses, controlled
82 substances in good faith to his patient for a medicinal or therapeutic purpose within the
83 course of his professional practice. In addition, a bona fide practitioner-patient
84 relationship means that the practitioner shall (i) ensure that a medical or drug history is
85 obtained; (ii) provide information to the patient about the benefits and risks of the drug
86 being prescribed; (iii) perform or have performed an appropriate examination of the
87 patient, either physically or by the use of instrumentation and diagnostic equipment
88 through which images and medical records may be transmitted electronically; except for
89 medical emergencies, the examination of the patient shall have been performed by the
90 practitioner himself, within the group in which he practices, or by a consulting
91 practitioner prior to issuing a prescription; and (iv) initiate additional interventions and
92 follow-up care, if necessary, especially if a prescribed drug may have serious side
93 effects. ~~An examination performed using telemedicine services, as defined in~~
94 ~~subsection B of § 38.2-3418.16, shall be sufficient to meet the requirement for an~~
95 ~~"appropriate examination" pursuant to clause (iii). If the telemedicine services~~
96 ~~practitioner prescribes medication other than Schedule VI controlled substances to a~~
97 ~~patient, at least one in-person physical examination must have occurred.~~

98 For the purpose of prescribing a Schedule VI drug to a patient, a prescriber may
99 establish a bona fide patient-practitioner relationship by an examination through face-to-
100 face interactive, two-way, real-time communications services or store and forward
101 technologies when all of the following conditions are met: 1) the patient shall have
102 provided a medical history which is available for review by the prescriber; 2) that the
103 prescriber obtains an updated history at the time of prescribing; 3) that the prescriber
104 makes a diagnosis at the time of prescribing; 4) that the prescriber conforms to the
105 standard of care expected of in-person care as appropriate to the patient's age and
106 presenting condition, including where the standard of care requires the use of diagnostic
107 testing and the performing of a physical examination which may be carried out through
108 the use of peripheral devices appropriate to the patient's condition; 5) that the prescriber
109 is actively licensed in Virginia and authorized to prescribe; 6) that, if the patient is a
110 member or enrollee of a health plan or carrier, the prescriber has been credentialed by
111 the health plan or carrier as a participating provider and that the diagnosing and
112 prescribing meets the qualifications for reimbursement by the health plan or carrier
113 pursuant to § 38.2-3418.16; and 7) upon request, the prescriber shall provide patient
114 records in a timely manner in accordance with provisions of § 32.1-127.1:03 and all
115 other state and federal laws and regulations. Nothing in this paragraph shall permit a
116 prescriber to establish such a relationship for the purpose of prescribing a Schedule VI
117 drug when the standard of care dictates that an in-person physical examination is
118 necessary for diagnosis.

119 Any practitioner who prescribes any controlled substance with the knowledge that the
120 controlled substance will be used otherwise than medicinally or for therapeutic purposes
121 shall be subject to the criminal penalties provided in § **18.2-248** for violations of the
122 provisions of law relating to the distribution or possession of controlled substances.

123 B. In order to determine whether a prescription that appears questionable to the
124 pharmacist results from a bona fide practitioner-patient relationship, the pharmacist
125 shall contact the prescribing practitioner or his agent and verify the identity of the patient
126 and name and quantity of the drug prescribed. The person knowingly filling an invalid
127 prescription shall be subject to the criminal penalties provided in § **18.2-248** for
128 violations of the provisions of law relating to the sale, distribution or possession of
129 controlled substances.

130 No prescription shall be filled unless there is a bona fide practitioner-patient-pharmacist
131 relationship. A prescription not issued in the usual course of treatment or for authorized
132 research is not a valid prescription.

133 C. Notwithstanding any provision of law to the contrary and consistent with
134 recommendations of the Centers for Disease Control and Prevention or the Department
135 of Health, a practitioner may prescribe Schedule VI antibiotics and antiviral agents to
136 other persons in close contact with a diagnosed patient when (i) the practitioner meets
137 all requirements of a bona fide practitioner-patient relationship, as defined in subsection
138 A, with the diagnosed patient; (ii) in the practitioner's professional judgment, the
139 practitioner deems there is urgency to begin treatment to prevent the transmission of a
140 communicable disease; (iii) the practitioner has met all requirements of a bona fide
141 practitioner-patient relationship, as defined in subsection A, for the close contact except
142 for the physical examination required in clause (iii) of subsection A; and (iv) when such
143 emergency treatment is necessary to prevent imminent risk of death, life-threatening
144 illness, or serious disability.

145 D. A pharmacist may dispense a controlled substance pursuant to a prescription of an
146 out-of-state practitioner of medicine, osteopathy, podiatry, dentistry or veterinary
147 medicine authorized to issue such prescription if the prescription complies with the
148 requirements of this chapter and Chapter 34 (§ **54.1-3400** et seq.), known as the "Drug
149 Control Act."

150 E. A licensed nurse practitioner who is authorized to prescribe controlled substances
151 pursuant to § **54.1-2957.01** may issue prescriptions or provide manufacturers'
152 professional samples for controlled substances and devices as set forth in Chapter 34
153 (§ **54.1-3400** et seq.) in good faith to his patient for a medicinal or therapeutic purpose
154 within the scope of his professional practice.

155 F. A licensed physician assistant who is authorized to prescribe controlled substances
156 pursuant to § **54.1-2952.1** may issue prescriptions or provide manufacturers'
157 professional samples for controlled substances and devices as set forth in Chapter 34

158 (§ **54.1-3400** et seq.) in good faith to his patient for a medicinal or therapeutic purpose
159 within the scope of his professional practice.

160 G. A TPA-certified optometrist who is authorized to prescribe controlled substances
161 pursuant to Article 5 (§ **54.1-3222** et seq.) of Chapter 32 may issue prescriptions in
162 good faith or provide manufacturers' professional samples to his patients for medicinal
163 or therapeutic purposes within the scope of his professional practice for the drugs
164 specified on the TPA-Formulary, established pursuant to § **54.1-3223**, which shall be
165 limited to (i) oral analgesics included in Schedules III through VI, as defined in §§ **54.1-**
166 **3450** and **54.1-3455** of the Drug Control Act (§ **54.1-3400** et seq.), which are
167 appropriate to relieve ocular pain, (ii) other oral Schedule VI controlled substances, as
168 defined in § **54.1-3455** of the Drug Control Act, appropriate to treat diseases and
169 abnormal conditions of the human eye and its adnexa, (iii) topically applied Schedule VI
170 drugs, as defined in § **54.1-3455** of the Drug Control Act, and (iv) intramuscular
171 administration of epinephrine for treatment of emergency cases of anaphylactic shock.

172 H. The requirement for a bona fide practitioner-patient relationship shall be deemed to
173 be satisfied by a member or committee of a hospital's medical staff when approving a
174 standing order or protocol for the administration of influenza vaccinations and
175 pneumococcal vaccinations in a hospital in compliance with § **32.1-126.4**.

176 DM # 685210 v10

Statement of Stephen M. Scheinthal, DO, dFACN, DFAPA

New Jersey Association of Osteopathic Physicians and Surgeons

Senate Health and Human Services Committee

Hearing on Telemedicine

November 9, 2015

Thank you, Mr. Chairman for the opportunity to present testimony on this critical issue. My name is **Stephen Scheinthal, DO**. In terms of my professional qualifications, I am a board certified geriatric psychiatrist and Professor of Psychiatry and Chair of the Rowan University School of Osteopathic Medicine, Department of Psychiatry. I am a graduate of UMDNJ-SOM where I completed my internship, psychiatry residency, and geriatric psychiatry fellowship.

Today, I am here on behalf of the ***New Jersey Association of Osteopathic Physicians and Surgeons (NJAOPS)***, representing more than 5,000 osteopathic physicians, residents, interns and medical students in New Jersey.

We join with our national association, the **American Osteopathic Association** in supporting the concept of telemedicine. Further, we believe that technology must be used to increase access to care, while not diminishing quality or the patient centered basis for such care.

Obviously, with the swift pace of technology today, telemedicine is an evolving practice; both in the scope of practice that is covered and in the overall meaning of the term "telemedicine". Despite, its advantages we are concerned over lack of regulation and oversight to control this practice.

We believe the primary issues involving telemedicine are: licensure of out of state practitioners, technological problems and barriers, quality of care, and reimbursement issues concerning payment for services rendered.

In order to prevent diminished quality of care moving forward, we support state based licensure and discipline oversight. Currently, New Jersey has regulations on this topic and these should not be replaced by less restrictive parameters but should be enhanced by any new state statutory standards.

Another of our core beliefs on this topic is that physicians are practicing medicine, in the absence of physical interaction, when medical services are being provided through simultaneous two way communication. In acknowledging that, we recognize that some services may require appropriate and corresponding delays in said communication.

Moreover, NJAOPS believes that the standard of care provided through the use of technology should be equivalent to that of the care provided when the physician and the patient are within close proximity. The technological network being used to deliver patient care must have protocols in place that ensure the stability and security of that network to comply with applicable state and federal laws regarding patient privacy issues

Scopes of practice issues remain a primary concern as well, and we believe the scope of care being delivered by physicians and other health care providers through telemedicine should not exceed the education, training stipulated in applicable state and federal law.

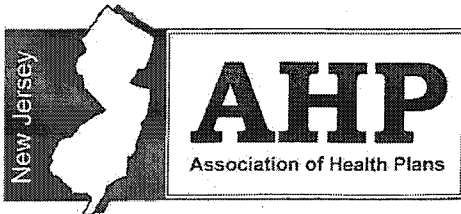
We also believe that when malpractice claims arise from care provided through technological means, when the physician and patient are located in separate jurisdictions, these claims should be adjudicated under the process currently utilized by the judicial system. . The plaintiff's current ability to determine the venue where the case is filed must be preserved. Physicians must provide complete transparency to their patients regarding their location, jurisdiction of licensure and any limitations of the technology used to deliver care.

Once again, thank you for the opportunity to share our views on this important topic Mr. Chairman, you and the members of the committee are to be commended for holding this exploratory hearing. We look forward to working

with you and the members of the committee to ensure that the appropriate laws applying to this important issue are in place.

For More Information Contact: Laurie A. Clark – Legislative Counsel to NJAOPS

732-940-9000



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Wardell Sanders
President

Sarah M. Adelman
Vice President

**Testimony of the
New Jersey Association of Health Plans
For the Senate Health, Human Services and Senior Services Committee
November 9, 2015**

Chairman Vitale and Members of the Senate Health, Human Services and Senior Services Committee:

The New Jersey Association of Health Plans (“NJAHPP”) is a non-profit association representing leading health care plans in the state which cover nearly seven million New Jersey residents. Our members include Aetna, AmeriGroup, AmeriHealth, Cigna, Health Republic, Horizon Blue Cross Blue Shield of New Jersey, Oscar, UnitedHealthcare, and WellCare. Thank you for the invitation to speak on telemedicine in general, including the current and potential applications of telemedicine services in New Jersey.

Technology has and continues to provide new tools to improve care and patient outcomes. Improvements in technology and increased consumer access to website portals, email, video transmission, and telephonic communications have opened up new models for consumers to access medical services, which hold enormous promise to eliminate distance barriers and improve access to needed medical services. Of course, as with other technology, these methods can be a cost-saver, cost-neutral, or a cost-driver. Regulatory structures around telemedicine can play an important role in determining whether telemedicine can achieve its goals of increasing access to care. Sound policy making is critical to the proliferation of safe and secure telehealth models. We thank this Committee for hearing from interested stakeholders prior to consideration of any legislation.

Background

With the expansion of coverage under the Affordable Care Act, more Americans have coverage further burdening an already overworked health care system. Access to health care can also be challenging due to affordability, wait times for visits and a shortage of certain providers. Telemedicine offers the promise of reducing wait times, bridging geographic distances, reaching certain specialists, and leveraging emerging technologies to help solve health care access challenges. Moreover, telemedicine offers an opportunity to provide high-quality, secure, convenient and cost-effective care.

Across the country, states are passing legislation relating to telemedicine. By our count, twenty-nine states and the District of Columbia have passed mandates requiring private insurers to cover telehealth services. And state Medicaid offices have addressed this through the development of payment policies for telemedicine. Here in New Jersey, NJ FamilyCare has a program for telemedicine for psychiatric care although its take up rate has been very modest. Moreover, about a fifth of all states have adopted some or all of the Federation of State Medical Boards Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine.

To learn more about the New Jersey Association of Health Plans, visit our website at njahp.org.

Current and Future Applications by Health Insurance Carriers

Medicare still defines telemedicine payment as only occurring when the patient is at a rural, clinical, originating site. However, Congress has been looking at ways to expand Medicare payment and demonstrating the clinical and financial value to serving this population through telehealth technologies.

For commercial insurers, the original applications of telemedicine had been to offer services as a value-add, non-insured benefit. Nurse hotlines and other means of accessing advice have been around for years. But the technology is rapidly improving and consumer access is expanding. As a result, carriers are increasing the ways in which telemedicine is employed.

Carriers are increasingly building into their insured benefits a telemedicine option. As a reflection of this, recently, the New Jersey Small Employer Health Benefits Program Board, the regulatory body charged with drafting the standardized contracts issued by carriers in that market, proposed and adopted health benefit plan policy form language to allow carriers the option to provide coverage for telemedicine, e-visits and virtual visits.¹ The option allows the inclusion of these terms on the schedule page to allow carriers to specify any applicable cost sharing for each of these types of service, expands the practitioner charges section to explain that services provided as telemedicine visits, e-visits and virtual visits are covered under the plan, and modifies the exclusion for telephone consultations to create an exception for telemedicine, e-visits and virtual visits.

NJAHP's Principles for Telemedicine

As the New Jersey Legislature considers the expanded uses of telemedicine and considers regulatory standards, NJAHP would like offer some key principles that we would ask you to consider.

- **Defining Telemedicine:** "Telehealth" and "telemedicine" definitions should include the practice of health care delivery, diagnosis, consultation, treatment, care-management, valid prescribing of non-controlled substances, transfer of clinical information (e.g., x-rays, MRIs, EKGs, and lab results), and exchange of medical education information by means of real-time audio and video while the patient is at any location and the health care provider is at any other location.
- **Treatment Standards.** Treatment via telemedicine should be held to the same standards of practice as those in traditional settings.
- **Establishment of Relationship:** Regulatory standards should permit the physician-patient relationship to be established via telemedicine as long as it meets the applicable standard of care.
- **Provider Choice:** To the extent possible, consumers should have some choice in the selection of a provider through telemedicine.

¹ The rule defines each as follows:

- **E-VISIT.** A visit with a Provider using electronic means such as website portals, e-mail or other technology that allows communication between a Provider that has contracted with [Carrier] to offer E-visit services and [Members] who are established patients of the Provider.
- **VIRTUAL VISIT.** A visit with a Provider that has contracted with [Carrier] to diagnose and treat low acuity medical conditions through the use of interactive audio and video telecommunication and transmissions and audio-visual technology. A virtual visit provides real-time communication between the [Member] and the Provider.
- **TELEMEDICINE.** A telephone consultation between a Provider that has contracted with [Carrier] to offer telemedicine services and a [Member].

- **Prescribing:** The licensed provider should determine whether prescribing is appropriate.
- **Privacy Compliance:** All encounters should be compliant with all state and federal privacy standards.
- **Patient Location:** There should be no unnecessary restrictions that inhibit consumers' ability to securely access telemedicine services from any location, including work, school or the home.
- **Coverage and Reimbursement:** Use a flexible approach to coverage and reimbursement that accounts for advances in value-based benefit designs, payment and care delivery reforms and varying costs of telehealth services across geographic locations.
- **Networks:** Allow health plans to use designated networks to help consumers receive telemedicine services from health care professionals who deliver high-quality care.
- **Inter-state licensure:** Facilitate pathways to inter-state licensure and/or reciprocity for health care professionals, so that providers who deliver high-quality care can extend their reach beyond state lines to better serve local health-care needs.

NJAHP on Bills in New Jersey

While this hearing is about telemedicine in general, we do note that there are some bills that have been introduced that address telemedicine. Set forth below are some general observations about these bills.

A4231/S2729

NJAHP is supportive of language which does not set specific location requirements for patients to be at a particular facility in order to access telemedicine services and support options for patients to receive telemedicine services in the home. And as noted above, we support creating the same standard of care requirement between in-person care and telemedicine. We support that there be no in-person requirements to establish a physician-patient relationship.

Our key objection is to require payment parity between telehealth and in-person care. Facility and administrative fees are lower when the services are provided through telehealth; telehealth visits have lower overhead costs; and telehealth can help to address rising medical costs – but not if payment parity is mandated in law. Government rate-setting of this type is likely to hinder the proliferation of telemedicine in the state and blunt its effectiveness at increasing access and reducing costs for consumers.

A3674/S2337

NJAHP is supportive of the restrictions on the State Medical Board, effectively prohibiting it from enacting rules that could require in-person contact to establish a physician-patient relationship before allowing providers to conduct telemedicine with a particular patient.

A3675/S2338

As noted above, NJAHP is strongly opposed to mandating payment parity as doing so could thwart the benefit and availability of telemedicine. We also have some concerns about the coverage parity requirement in this bill. New Jersey's health plans would prefer the flexibility to structure health benefit plans consistent with their best judgment and to meet its customers' needs.

Again, thank you for the opportunity to testify on telemedicine in New Jersey.



Senate Health, Human Services and
Senior Citizens Committee

November 9, 2015

**Testimony of Linda J. Schwimmer, President & CEO of the New
Jersey Health Care Quality Institute on the Role of Telemedicine in
Health Care Delivery**

Good afternoon, my name is Linda Schwimmer and I am the President and CEO of the New Jersey Health Care Quality Institute. The Quality Institute, with more than 100 member organizations is a statewide health improvement collaborative and is recognized as an objective, nonpartisan, nonprofit organization working to ensure that the highest levels of quality, safety, transparency and cost containment are integral to the delivery of health care in New Jersey.

We appreciate the opportunity to speak today on the role of telemedicine in health care delivery in New Jersey. Telemedicine is a vital adjunct to hands-on care. Even though New Jersey has many physicians, it is sprinkled with underserved areas where there is limited access to many kinds of medical services, both primary care and specialty. There is a real future for telemedicine as a supplement to local in-person resources, both to advise physicians (think physician-to-physician consults from specialists to primary care providers, for example), as well as a source of direct care or advice for patients with low-level medical problems. In particular, behavioral health is a real area of opportunity, since it rarely involves hands-on treatment and there is a major shortage of providers, especially those who speak the languages of a multi-cultural population.

We agree that there is a role for the state to play in both removing regulatory barriers that stand in the way of greater use of telemedicine but also to ensure that consumer protections are in place as this new way of delivering care expands.

There has been a growing trend in the use of telemedicine around the country and the world and we can already see great advantages.

1. **Access:** For the frail elderly and those in geographically remote locations, medical consultation through telephone and video allows consumers a convenient and timely way to access care from the comfort and safety of their own homes.
2. **Timeliness:** Wait times to see specialists such as neurologists and dermatologists can be greatly decreased, meaning that patients can get quicker diagnosis and begin treatment in a timely

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Manager, Policy & Planning
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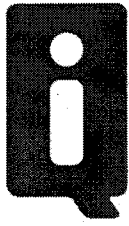
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manner. Openness to allowing and reimbursing for “store & forward” computer-based communication between patient (Direct to Consumer) and provider, or between provider and specialist (Provider to Provider) for diagnosis and therapeutic assistance for patients who would otherwise not have timely access to specialty care. It is already common in radiology and pathology but could be used in a broader way.

3. **Chronic Conditions:** By utilizing remote monitoring and sensing mechanisms of important health information such as blood sugar, pulse-ox and blood pressure, physicians and nurses can provide more convenient and consistent monitoring for those with chronic conditions. Patients can be more engaged in working to manage their chronic illnesses and will be more likely to be compliant with medications and testing when they can do it without missing a day at work or driving for miles to go to a medical appointment.
4. **Care Coordination:** As we move toward value-based payments, telemedicine can be used to facilitate communication between members of a care team. Better information sharing between providers will improve the care delivery and coordination, resulting in healthier patients and better outcomes.
5. **Alleviate provider shortages:** Particularly in the area of behavioral health, where New Jersey, like the rest of the country, suffers from a significant lack of enough mental health providers to meet all of our residents’ needs, the use of telemedicine can be beneficial. More primary care practices could initiate mental health treatment and support their work with the teleconsultation of specialists in remote locations. For an example of how this has worked well in Washington State, please see the presentation (<http://www.njhcqi.org/wp-content/uploads/2015/10/ACO-Conference-Slides-Final.pdf>) by Dr. Jurgen Unutzer who presented his work at our QI Collaborative Medicaid Payment Reform Summit in October.

The two biggest challenges the state will face in creating an environment to allow expansion of telemedicine are payment and coverage for service. The state should review the regulatory barriers currently in place that prevent all plans, both commercial and state funded, from better



utilizing telemedicine. Review of regulations should include topics such as service coverage, payment methodology, distance requirements, eligible patient populations & health care providers, authorized technologies and patient consent.

In addition to removing barriers, the state should also consider **consumer protections** that should be included in any revision of state law and regulations. These include:

1. **Privacy protections:** Ensuring that conversations and records shared remotely should be safely protected to comply with HIPPA.
2. **Complete medical records:** Telemedicine consultations should be made part of a patient's record to ensure that all providers, both those only seen remotely and those in brick and mortar settings have access to the comprehensive records of a patient.
3. **Recognizing consumer choice:** As we move to more use of telemedicine, it is important to consider the needs of the patients. It is true that Millenials might be more comfortable than our retirees in accessing medical care remotely, so that patient consent should be a factor in receiving care through alternative means.
4. **Quality:** Oversight, evaluation and outcomes monitoring must be emphasized to ensure high quality care is not lost in this change in delivery.

Thank you again for inviting me to speak today. The New Jersey Health Care Quality Institute is uniquely situated in that our members include all of the health care stakeholders in New Jersey. We would be happy to assist the committee or others in convening parties to form a proposal to best address this issue for the residents of New Jersey.

Innovating for Progress | Partnering for Solutions
New Jersey Association of Mental Health and Addiction Agencies, Inc.

The Honorable Joseph F. Vitale, Chairman
Senate Health, Human Services and Senior Citizens Committee
569 Rahway Avenue
Woodbridge, NJ 07095

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Chief Executive Officer

Debra L. Wentz, PhD

**Testimony Regarding Current and Potential Applications
of Telemedicine Services**

Dear Chairman Vitale and Members of the Committee:

On behalf of the New Jersey Association of Mental Health and Addiction Agencies, Inc. (NJAMHAA), I would like to thank Chairman Vitale, Vice-Chairman Madden and the members of the Committee for the opportunity to testify regarding current and potential applications of telemedicine services.

NJAMHAA represents 160 hospital-based and freestanding non-profit mental healthcare and substance abuse treatment providers who treat New Jersey residents with mental illness, addictions or co-occurring disorders, as well as the families of these individuals. Our membership represents organizations in every county and almost every community statewide – nearly 98 percent of the behavioral healthcare market in New Jersey. Collectively, our member organizations help 500,000 children and adults annually.

The promises of telemedicine are great, including lowering hospital admissions. Many in the mental health field anticipated that telepsychiatry would be a cost-effective way to address the critical shortage of psychiatrists. Unfortunately, the practice has had little impact on the Division of Medical Assistance and Health Services' (DMAHS') goal of improving access to psychiatric services. NJAMHAA and its members were pleased when DMAHS made it possible to bill Medicaid for telepsychiatry as face-to-face visits and we continue to fully support the practice; however, capital costs and inadequate rates have kept providers from taking advantage of this technology.

While the basic equipment for telemedicine can be purchased at relatively moderate prices, many other costs come in to play. Primary among them is the need for private space in which to conduct telehealth visits. New Jersey requires that telepsychiatry clients receive services at a "mental health clinic or



NJAMHAA

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New Jersey Association of Mental Health and Addiction Agencies, Inc.

outpatient hospital program”. A primary goal of telepsychiatry is to aid underserved and unserved areas, particularly rural areas, yet a client still needs to travel to the nearest clinic to gain access to a psychiatrist.

As favor builds for “buddy systems” whereby psychiatrists offer consultation services to primary care physicians, changes to telepsychiatry requirements are needed to foster the growth of such collaboratives.

Those agencies that have managed to cover the capital costs of providing telepsychiatry services have found that the reimbursement rates are too low to maintain it. The fact that New Jersey’s Medicaid rates across the board are among the lowest in the country is well-known; the ability to optimize resources through telehealth is one more casualty of those low rates.

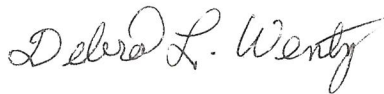
Adding to the challenges of optimizing this technology is the fixed capacity of psychiatric time at a time of increasing demand. Telepsychiatry is supposed to stretch the supply of psychiatrists, but, as one psychiatrist notes, “every patient (he sees remotely) is a patient (he) can’t see” face to face.

With full support for maximizing the use of telemedicine to increase, to the extent possible, access to psychiatrists, NJAMHAA recommends:

- A grant program for capital costs of equipment and space renovations.
- Changes to limitations on where a client may take part in telepsychiatry visits.
- Increase the Medicaid reimbursement rates for face-to-face visits.
- More resources, including loan repayments, devoted to encouraging entry into psychiatry; providing financial support to students of psychiatry; and encouraging service in the non-profit community based systems of care.

Thank you for the opportunity to be heard. I would be happy to answer any questions from the Committee. Please feel free to contact me at 609-838-5488 extension 292 or at dwentz@njamhaa.org.

Sincerely,



Debra L. Wentz, Ph.D.
Chief Executive Officer





Testimony prepared for:

Senate Health, Human Services & Senior Citizens Committee

November 9, 2015

Regarding: Application of Telemedicine Services in New Jersey

Presented by:

Tarun Kapoor, M.D., FHM, Vice President and Senior Medical Director, Virtua Medical Group

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The Virtua Medical Group (VMG) consists of 365 clinicians who see 150,000 patients assigned to our medical home. Last year, our VMG practice group saw over 700,000 patient visits. Virtua is the largest healthcare system in Southern New Jersey and one of the largest in the state, employing more than 8,700 people and serving a population well over a million. We operate three acute care hospitals, and over 80 outpatient locations primarily in Burlington, Camden and Gloucester counties. Last year, Virtua provided care to over 1 million inpatient, ER and outpatient patient encounters.

Chairman Vitale, Vice-Chair Madden and Committee Members:

I am Tarun Kapoor, M.D., Vice President and Senior Medical Director of Virtua Medical Group at Virtua, also known as VMG. Thank you for the opportunity to talk with you today about **telemedicine services in New Jersey.**

As healthcare delivery is rapidly evolving and more New Jerseyans are gaining health coverage, people’s desire for greater access to care is spurring demand for telemedicine services. At Virtua, we have been providing telemedicine services for more than a decade, and today we are working to grow our telemedicine footprint to meet the demands of our community.

Over the past few years, Virtua has invested heavily in a wide range of technology – from electronic medical records to communications systems. In fact, Virtua’s investments in technology over the last 10 years exceed \$200 million dollars.

Our investments in technology include support for a variety of telemedicine services. At Virtua, we believe that technology has a pivotal role in the way we deliver healthcare services. Our goal in providing telemedicine

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services is simple, we see our telemedicine programs as an extension to our ability to achieve the triple aim -- improve quality, reduce costs and enhance patient experience.

I will now discuss what we are providing in telemedicine services and then talk to you about what we plan to offer in the next 12 months.

In 2014, Virtua provided thousands of consultations in telemedicine, within many medical disciplines, ranging from pediatrics and neurology to psychiatry.

Neurology: Virtua has been providing tele-neurology services in all of our emergency departments for more than 10 years. When patients need specialized neurology consults, Virtua neurology telemedicine may be used. Teleneurology allows a neurologist, equipped with proper technology, to cover many emergency departments at the same time. To provide this service, Virtua partners with Specialists on Call, a Joint Commission-accredited provider of emergency telemedicine. This partnership provides innovative and immediate care with 24/7/365 access to experienced, board certified specialists. Through tele-neurology, a neurologist can examine a potential stroke patient, with the emergency room physician and staff at the patient's bedside to determine if the patient is a candidate for *tissue plasminogen activator (tPA)* that can reduce stroke damage. Tele-neurology is critical in these cases as the drug must be administered in the first three hours after the onset of the stroke. In 2014, Virtua facilitated nearly 1,700 tele-neurology consults for patients.

Pediatrics: When patients come into one of our pediatric emergency departments, we have the ability to get second opinions on complex cases from pediatric subspecialists. The telemedicine program with Children's Hospital of Philadelphia allows for pediatric intensivists to interact with patients and their families who are receiving care at a Virtua facility. Virtua facilitated 76 physician consultations with The Children's Hospital of Philadelphia in 2014.

Behavioral Health: Virtua partners with the Center for Family Guidance to provide tele-psychiatry services in all of our emergency departments. This partnership provides our patients who need services with a network of psychiatrists who are available 24/7 to conduct psychiatric evaluations and medication management using televideo conferencing. This service is extremely valuable because it allows a patient's access to a behavioral health professional via technology when one is unable to physically attend to the patient's needs in the emergency department. In 2015, we have treated 167 patients with this service year to date.

Home Monitoring Devices:

Virtua has invested in telemedicine home monitoring devices to help reduce avoidable readmissions. These devices take blood pressure, weight and pulse ox. By following up with our most severe chronic diseases

patients, we can implement interventions in real time. Our expert team of care coordinators follows up remotely with patients in real time every day to follow up on their health conditions post discharge.

Moving Forward:

The four telemedicine services that I just described help us to better provide our patients with the specialty care they need. With the goal to increase access and lower costs, we are presently working to deploy new telemedicine programs within the next 12 months.

At Virtua, we already use Store-and-Forward, which involves the taking of a radiologic image (for example, a CT scan, film X-ray, or MRI study) at a Virtua facility, which is then transmitted (or “forwarded”) to an off-site radiologist who interprets the image and writes a report. The report is then digitally sent to the hospital for use in the patient’s care. On-average, 680 radiologic images per month are interpreted in this Store-and-Forward method at the three Virtua hospitals combined.

A second example of the Store-and-Forward involves the taking a digital photograph which is then sent to an off-site dermatologist or wound-care specialist. Virtua presently does not perform this second example, but it is under consideration for some time in 2016. The digital camera that is used for this example creates highly pixelated photographs, allowing the off-site physician to readily visualize the dermatologist condition. Some would also argue that the highly-pixelated photograph creates a better image than one would “see” with the naked eye.

Another new telemedicine program we plan to activate involves real-time interaction between a patient and a physician.

This involves a patient who is communicating with the physician via the telephone or video. In 2016, our Medical Group will be offering this service to established patients, at scheduled appointment times. In effect, the “telemedicine visit” can replace the in-person office visit under certain circumstances. These visits will be conducted either by telephone or video, augmented by use of an on-line medical history record or EMR. At this time, we have not established a fee for this service, and we are aware that such a method of care is not reimbursed by insurance plans.

In a similar scenario, Virtua has contracted with a telemedicine provider to offer telemedicine consultations to Virtua patients and Virtua employees and their dependents through the Virtua employee benefit program. Ten (10) physicians in the Virtua Medical Group have contracted with Teladoc to be part of Teladoc’s New Jersey-licensed pool of physicians who will conduct these telemedicine visits for our patients who declare Virtua Medical Group as their medical home. This is a coverage agreement for our patients who are seen by us and

this is a new and innovative way to enhance their care experience, and it will be available 24 hours a day, “on-demand.” We also plan to grow our “on-demand” telemedicine programs for our patient community as well. This would allow real-time interaction for patients needing to speak with one of our doctors.

This service will be available starting January 1st. Last year, Virtua provided over 200,000 emergency department patient visits. Of these, 44% of visits were low acuity which would have been better suited to a lower care setting such as primary care or urgent care. If these patients utilized better care settings for their conditions, such as primary care and telemedicine, the costs savings would exceed \$160 per patient annually and \$14 million to the NJ economy.

Also, when you think of today’s high-deductible health insurance plans, consumers sometimes avoid going to the doctor or the emergency room because of the financial implications. If I can treat a patient over the phone and help them get care they need for their asthma medication refill as an example, I think that’s a better and more affordable option than going to the emergency room.

As an internal medicine doctor for over 12 years, I spend my time differently today treating patients than I did when I just got out of training. At Virtua Medical Group, we do not work a traditional 9 AM to 5 PM schedule, Monday through Friday with weekends and holidays off. The reason is quite simply that in the medicine of today, we need to get to patients on their terms. We would very much like for patients to come to into our offices and conform to our schedules and availability, but that simply does not work for our patients. Many of them have transportation limitations, caregiver responsibilities or jobs that are require them to take paid time off to come to the doctor’s office.

In addition, today, there are super groups of physician practices, and our medical group has embraced this clinical model of working in teams to treat a population of people. This coverage model works. We would love for a patient to exclusively work with one clinician who could handle every single disease process the patient would ever experience. But with medical knowledge nearly doubling every two years and the increasing ability to treat ever more complex diseases in an outpatient setting, we have to work in teams to be able to care for patients surviving longer with chronic diseases. Hence, clinicians today need to cover for each and communicate directly with patients with the technologies available to us.

Today we are talking about telemedicine as an extension of the care we as physicians already provide. Telemedicine has been in use in the United States since 1875, the year Alexander Graham Bell invented the telephone. Last year, the VMG practice group received over 100,000 phone calls about medication management and medical advice alone. These calls required patient to clinician telephone conversations, many

of which occurred with a covering clinician. Also, in "off-hours," our clinicians cover for one another to try to ensure there is always someone for our patients to speak with 24 hours a day, 365 days a year.

Doctors talk on the phone all day, we talk with patients, nurses and sometimes caregivers. As healthcare professionals, we are responsible for delivering effective and safe care to patients reaching out to us for help. While there are numerous cases where a face-to-face visit and thorough physical exam are needed to offer effective and safe care, there are just as many non-emergent clinical scenarios where a conversation between a physician and patient can answer questions about a medication reaction, a persisting cough or a question about whether your child should stay home from school.

A telemedicine consultation is similar to a low-level urgent care visit, where a patient is accessing care for a low-level acute condition, taking advantage of the convenience factor (24 x7).

The ease of internet-based technology has now made it easier for patients to use telemedicine services, which allows consumers to summarize their health history (including medications) and then to request a consultation via interactive audio or video--in fact, over 90% of patients select interactive audio.

Physicians are trained to listen to a patient and make sound medical decisions. A major part of what we do for patients is anticipatory guidance, education and reassurance.

Closing Thoughts

In the future, we would like to see telemedicine services grow for patients and people living in our communities. We believe this is a cost-effective healthcare service that provides the community and our patients with the quality of care they need and in a timely and efficient manner.

Moving forward, we support legislation that supports reimbursement for telemedicine services and also provides oversight to ensure quality. Virtua would also support telemedicine legislation that modernizes our laws and promotes the advancement of telemedicine that can improve patients' access to the quality of care that they need.

Also, we recommend that any legislation should not exclude "audio only" from its definition of telemedicine. There are populations of people like seniors and the underserved who do not have high speed internet, or know how to use video technology through a smart phone or sometimes have a smart phone. The telephone is a universal way to communicate.

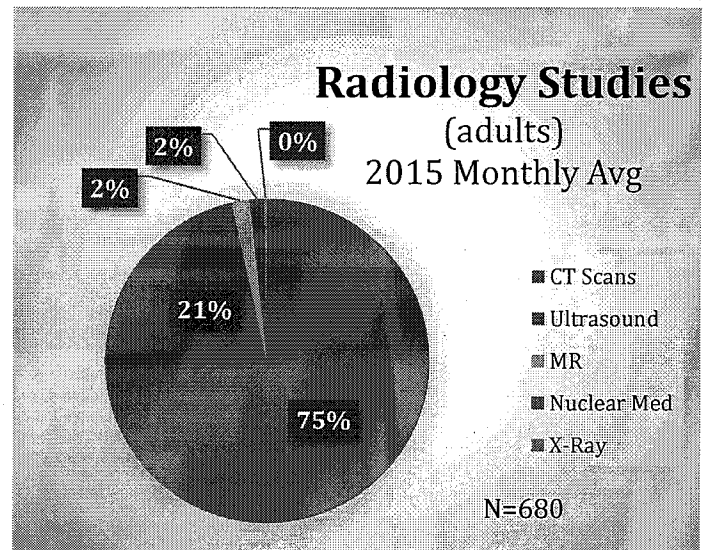
As this Committee considers telemedicine policy and legislation, please consider Virtua a resource. Thank you.

Virtua Telemedicine Services

Store-and-Forward

Radiology Studies

- For adults, an image taken at a Virtua facility is transmitted to an off-site radiologist, primary during evening hours
- On Average – 680 Studies/Month
 - CT Scans – 513/month
 - US – 143/month
 - MR – 12/month
 - Nuclear Med – 10/month
 - X-Ray – 2/month
- For pediatric radiology studies, every film is interpreted by a Children’s Hospital of Philadelphia radiologist in a near-real-time store-and-forward method.



Remote Device Monitoring

Home Care Devices

- Deployed to 30-40 patients at any given time with a capacity of 60 patients
- Tracks vital signs, blood pressure, blood oxygen levels, body weight and blood glucose
- Benefits
 - Reduced re-hospitalizations due to proactive disease management
 - Increased patient engagement and compliance with plan of care
 - Improved preventative disease management of chronic conditions
 - Patient and caregivers empowered by involvement in self-care
 - Increased patient accountability for their care
 - Better targeted in-home visits due to daily data collection of telehealth readings
 - Increased case collaboration between homecare nurse, telehealth nurse, and physician
 - Telehealth signals the onset of potential adverse events, alerting for the need for intervention to prevent the need for costly emergent care visits or hospital admissions

Synchronous Telemedicine Interactions

Virtua Medical Group (2016)

- Offering established patients telemedicine visits by telephone or video
- Not currently reimbursable by insurance plans

Tele-Pediatrics – Children’s Hospital of Philadelphia (CHOP)

- Launched at Voorhees in 2012 with limited CHOP Neuro coverage
- Virtua facilitated 76 telemedicine consults with The CHOP in 2014
- Reduces Neuro transfers out of Virtua
- Working to improve subspecialty access and availability
- Currently performing remote CHOP Tele-radiology rounds in Voorhees NICU





The Dermatological Society of New Jersey Setting the Standard in Dermatology™

November 4, 2015

Teledermatology Policy Statement

The Dermatological Society of New Jersey (DSNJ), founded in 1935, represents over 200 New Jersey dermatologists through all stages of their career. Our mission is to promote the highest standards of dermatologic care and service in New Jersey. The DSNJ provides strong representation to the Medical Society of New Jersey, American Academy of Dermatology, and Medicare Carrier Advisory Committee.

Telemedicine is an innovative, rapidly evolving method of care delivery. The DSNJ supports the appropriate use of telemedicine as a means of improving access to the expertise of New Jersey dermatologists to provide high-quality, high-value care. Telemedicine can also serve to improve patient care coordination and communication between other specialties and dermatology.

Teledermatology is one of the most active applications of telemedicine rendered in the United States. Dermatology is particularly suited to the use of this advanced technology for delivery of care because of its use of visual cues that are easily captured by imaging technologies. In addition, teledermatology can lead to significant benefits including immediate and improved patient access, fewer unnecessary in-person visits, and increased patient satisfaction and convenience. While teledermatology is a viable option to deliver high-quality care to patients in some circumstances, the DSNJ supports the preservation of a patient's choice to have access to in-person dermatology services. There are differences between care delivered via teledermatology and care delivered in person, both of which are advantageous in different care circumstances. Importantly, extra caution needs to be exercised when evaluating pigmented lesions through teledermatology.^{1,2} Teledermatology was not meant to be used for total body skin exams; therefore, the submitting clinician must be skilled at sampling the most worrisome pigmented lesions, lower their threshold for suspicious skin lesions, or refer to a dermatologist.³

Teledermatology is the practice of medicine. Dermatologists have extensive knowledge and expertise in cutaneous medicine, surgery, and pathology. Whether in-person or via teledermatology, the optimal delivery of dermatologic care involves dermatologists.

1. **Licensing**: Interactive telemedicine between patient and physician is equivalent to direct patient contact, and the physician or other health care provider should be licensed in the state where the patient is located. However, New Jersey should allow a physician in another state to act as a consultant to a locally licensed doctor through store-and-forward technology, as long as responsibility for the care and treatment of the patient is not transferred to the remote consulting physician.

2. **Professional Liability**: The diagnostic and therapeutic recommendations rendered through teledermatology are based solely on the information provided. Therefore, any liability should be based on the information available at the time of the encounter.

3. **Reimbursement**: Health care services delivered through telemedicine should be reimbursed at a rate that is equal to the reimbursement rate provided for in-person services.

4. **Patient Choice**: A health insurance policy should not financially incentivize or coerce individuals covered by the policy to use telemedicine in lieu of an in-person service with a community provider.

5. **Provider-Patient Relationship**: The health care provider should:

(a) maintain a provider-patient relationship with the individual and prior to treatment of the individual, provide an appropriate virtual face-to-face examination that includes real time video conferencing and incorporates any peripherals and diagnostic tests necessary to provide an accurate diagnosis, if a face-to-face examination would otherwise be medically appropriate in the provision of the same service not delivered via telemedicine; or

(b) establish a telemedicine provider-patient relationship that meets standards included in evidence-based clinical practice guidelines that were developed by a nationally recognized major medical society for a specialty whose Board is a member of the American Board of Medical Specialties (ABMS) or the American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS).

6. **Transparency and Truth-in-Advertising**: Health Care Providers must disclose their identity and applicable credentials, including license or title (eg: Physician, Nurse Practitioner, Physician Assistant, etc), specialty, and Board Certification from an ABMS or AOABOS member (where applicable).

1. Warshaw EM, Gravely AA, Nelson DB. Reliability of store and forward teledermatology for skin neoplasms. J Am Acad Dermatol. 2015;72:426-35.

2. Lamel SA, Haldeman KM, Ely H, Kovarik CL, et al. Application of mobile teledermatology for skin cancer screening. J Am Acad Dermatol. 2012;67:576-81.

3. Coates SJ, Kvedar J, Granstein RD. Teledermatology: From historical perspective to emerging techniques of the modern era. J Am Acad Dermatol. 2015;72:577-86.

**NEW JERSEY
PSYCHIATRIC
ASSOCIATION**

A District Branch of the American Psychiatric Association



NJCCAP

**New Jersey Council
Child & Adolescent Psychiatry**

Telepsychiatry

Position Paper

Adopted by the NJPA Board of Trustees March 5, 2014

Adopted by the NJCCAP Executive Council March 3, 2014

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March 5, 2014

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Telepsychiatry

Position Paper

Inadequate access to psychiatric care, even in a populous state such as New Jersey, is a critical public health issue worsening with each passing day.¹²³ The National Institutes of Mental Health (NIMH) reports 26.2% of adults suffering from a diagnosable mental disorder.⁴ Less than one half of adults with serious mental illnesses in New Jersey are treated.⁵ Clinically significant mental impairments afflict 22.2% of adolescents aged 13 to 18.⁶

Untreated mental illness increases the risk of suicide, chronic medical conditions, substance abuse, shorter life expectancy, violence, victimization, unemployment, and homelessness.⁷⁸⁹¹⁰¹¹ The economic burden to the state by inadequately treated mental health disorders include increased utilization of emergency services, social support services, and criminal justice services including an increased prison population.¹²¹³¹⁴ In the United States, mental disorders in children have an estimated total annual cost of \$247 billion.¹⁵ Indirect costs, largely from decreased productivity from adults related to time expended on issues related to the care of their mentally ill offspring, is estimated at \$79 billion.^{16v}

¹ Grading the States 2009: A report of America's Health Care System for Adults with Serious Mental Illness; Aron et al.; Arlington, VA: National Alliance on Mental Illness, 2009

² Mental Health Surveillance Among Children — United States 2005–2011; Perou et al.; CDC Supplements; May 17, 2013; 62(02);1-35

³ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services Newsletter; vol 23:21; December 2013 at <http://www.njha.com/media/292399/Telepsychiatrymemo.pdf>

⁴ NIMH The Numbers Count: Mental Disorders in America at <http://www.nimh.nih.gov>

⁵ NAMI State Advocacy 2010. State Statistics: New Jersey at <http://nami.org>

⁶ Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication—Adolescent Supplement (NCS-A) Merikangas et al.; Journal of the American Academy of Child and Adolescent Psychiatry 1 October 2010 (49:10; 980-989)

⁷ National Institute of Health. Suicide in the U.S.: Statistics and Prevention at www.nimh.gov

⁸ Congruences in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. Colton et al.; Preventing Chronic Disease: Public Health Research, Practice and Policy, 3(2), 1-14. April 2006

⁹ Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 9th ed. Lippincott Williams & Wilkins. Philadelphia. 2009.

¹⁰ Long-term healthcare costs and functional outcomes associated with lack of remission in schizophrenia: A post-hoc analysis of a prospective observational study. Haynes et al.; BMC Psychiatry. Dec 5;12:222, 2012

¹¹ Life expectancy and cardiovascular mortality in persons with schizophrenia. Laursen et. al; Current Opinion in Psychiatry. 25(2):83-- 8, 2012

¹² Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 9th ed. Lippincott Williams & Wilkins. Philadelphia. 2009.

¹³ Mental Health Problems of Prison and Jail Inmates; Glaze et al.; U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics: Washington, D.C. Sep 2006

¹⁴ Prisoners in 2008, Sabol et al.; U.S. Department of Justice, Bureau of Justice Statistics

¹⁵ Mental Health Surveillance Among Children — United States, 2005–2011; Perou et al.; CDC Supplements; May 17, 2013 / 62(02);1-35

¹⁶ US Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, Md., U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 1999, pp.408-409, 411.18

Background Information

Broadly defined, telemedicine may encompass any use of technology (such as fax, email, text, etc.) in the service of providing clinical care. However, in the context of this document, telemedicine refers to the definition set forth by the Center for Medicare & Medicaid Service (CMS) - the use of technology to facilitate real time interactive communication between a patient and a physician at different sites.¹⁷

Telepsychiatry is telemedicine applied in the service of mental health care. Psychiatry is particularly well suited for telemedicine - largely relying upon a good clinical history and visual observation with only infrequent need for examination by physical contact.¹⁸ While direct physician-patient contact is largely preferable, telepsychiatry, properly implemented, can ameliorate the under- and unserved mental health care needs of New Jersey by increasing access in a safe and cost-effective way without a significant sacrifice to quality of care.

Increased Access

Psychiatrists and other physicians are less common in remote areas. Patients may have to travel significant distances to the nearest mental health clinic or hospital. Being impoverished compounds the difficulty further, with the cost of travel, limited public transportation options, and loss of income from several hours of travel.

With current advances in consumer technology, telepsychiatry is highly effective in increasing access to underserved areas needing psychiatric care.^{19,20} Mental health clinics could be established in more locations or community resources could employ telepsychiatry to enlist the services of a psychiatrist hundreds of miles away.

Clinical Effectiveness & Safety

Quality of care does not suffer with properly implemented telepsychiatry programs - diagnosis, treatment recommendations, and clinical outcomes in telepsychiatry programs are comparable to traditional in person sessions.^{21,22,23,24,25,26} A large body of evidence over the past decade has not documented any increased harm

¹⁷ at <http://www.cms.gov> Accessed Jan 27, 2014.

¹⁸ American Telemedicine Association Practice Guidelines for Video-Conferencing Based Mental Health, October 2009

¹⁹ at <http://www.psychiatry.org/practice/professional-interests/underserved-communities/telepsychiatry>

²⁰ Telepsychiatry in the 21st Century: Transforming Healthcare with Technology. Stacie Deslich et al. *Perspectives in Health Information Management* (Summer 2013): 1-17

²¹ The effectiveness of telepsychiatry measured using the Health of the Nation Outcome Scale and the Mental Health

²¹ Inventory. Kennedy et al.; *Journal of Telemed Telecare*. 2003;9(1):12-26.

²² Rural Telepsychiatry: The Future is Bright; Daughton et al; *Psychiatric Times*, Nov 2013

²³ Telepsychiatry: assessment of televideo psychiatric interview reliability with present and next-generation internet infrastructures. Yoshino et al.; *Acta Psychiatrica Scandinavica*. 2001;104(3):223-226

²⁴ Randomized clinical trial of telepsychiatry through videoconference versus face-to-face conventional psychiatric treatment; De Las Cuevas et al.; *Telemed Journal E Health*. 2006;12(3):341-350.

²⁵ Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment; Ruskin et al.; *American Journal of Psychiatry*. 2004;161(8):1471-1476.

²⁶ Can telepsychiatry replace in-person psychiatric assessments? A review and meta-analysis of comparison studies; Hyler et al.; *CNS Spectrum* 2005;10(5):403Y413.

or risks for patients in telepsychiatry programs²⁸²⁹. Patients with psychotic disorders, even those with delusions regarding television and video images, have been effectively treated by telepsychiatry services.³⁰³¹

In children and adolescents, a population with even greater difficulties with inadequate mental health care coverage, numerous studies of programs, both new and established demonstrate diagnosis and treatment via telepsychiatry did not differ from face-to-face visits.³²³³³⁴

Patient and provider satisfaction, when measured in studies of telepsychiatry and tele mental health, are consistent.³⁵³⁶³⁷³⁸ High levels of satisfaction may improve program adoption and treatment adherence. Families involved in telepsychiatry program also are satisfied in the care their children receive.³⁹⁴⁰⁴¹⁴²

Cost Effectiveness

Telemedicine, in particular telepsychiatry, is a cost-efficient model for treatment.⁴³⁴⁴⁴⁵⁴⁶ Additional costs can be as basic as broadband service, a secure videoconferencing service, a web camera, and a computer. Poor

²⁷ Empirical evidence on the use and effectiveness of telepsychiatry via videoconferencing: implications for forensic and correctional psychiatry; Antonacci et al.; Behavioral Science Law. 2008;26(3):253-269.

²⁸ Is telepsychiatry equivalent to face-to-face psychiatry? Results from a randomized controlled equivalence trial; O'Reilly et al. Psychiatric Services 2007;58(6):836-43.

²⁹ Treatment outcomes in depression: comparison of remote treatment through telepsychiatry to in-person treatment. Ruskin et al.; The American Journal of Psychiatry. 2004;161(8):1471-6.

³⁰ The use of videoconferencing with patients with psychosis: a review of the literature. Sharp et al. Annals of General Psychiatry. 2011;10(1):14.

³¹ Telepsychiatry: psychiatric consultation through two-way television. A controlled study. Dongier et al.; Canadian Journal of Psychiatry. 1986;31(1):32-4.

³² Telepsychiatry with children and adolescents: Are patients comparable to those evaluated in usual outpatient care?; Myers et al.; Telemed J E Health. 2004;10(3):278-285.

³³ A randomized controlled trial of child psychiatric assessments conducted using videoconferencing; Elford et al.; J Telemed Telecare. 2000;6(2):73-82.

³⁴ Treating childhood depression over videoconferencing; Nelson et al.; Telemed Journal E Health. 2003;9(1):49-55.

³⁵ Videoconferencing in child and adolescent telepsychiatry: a systematic review of the literature; Pesamaa et al.; Journal Telemed Telecare. 2004;10(4): 187-192.

³⁶ Evaluating satisfaction with a child and adolescent psychological telemedicine outreach service; Kopel et al.; Journal Telemed Telecare. 2001;7(suppl 2):35-40.

³⁷ Psychiatrists' satisfaction with telepsychiatry; Wagnild et al.; Telemed Journal E Health. 2006;12(5):546-551.

³⁸ Economic Evaluation in Telemedicine – Still Room for Improvement; Bergmo et al.; Journal of Telemed Telecare 16.5 (2010): 229-31

³⁹ Telepsychiatry with children and adolescents: Are patients comparable to those evaluated in usual outpatient care?; Myers et al.; Telemed J E Health. 2004;10(3):278-285.

⁴⁰ A randomized controlled trial of child psychiatric assessments conducted using videoconferencing; Elford et al.; J Telemed Telecare. 2000;6(2):73-82.

⁴¹ Child and adolescent telepsychiatry: utilization and satisfaction; Myers et al.; Telemed Journal E Health. 2008;14(2):131-137.

⁴² Feasibility, acceptability, and sustainability of telepsychiatry for children and adolescents; Myers et al.; Psychiatric

⁴² Services. 2007;58(11):1493-1496.

⁴³ at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>>

⁴⁴ Rural Telepsychiatry: The Future is Bright; Daughton et al; Psychiatric Times, Nov 2013

⁴⁵ Systematic review of cost effectiveness studies of telemedicine interventions; Whitten et al.; British Medical Journal 2002;324(7351):1434-1437

⁴⁶ Cost-effectiveness analysis of a rural telemedicine collaborative care intervention for depression; Pyne et al.; Archives of General Psychiatry. 2010;67(8):812-821.

access to medical services could delay treatment which may worsen prognosis. In remote areas, telemedicine reduces time to diagnosis.⁴⁷

Telepsychiatry programs limit costs by reducing hospital admissions and emergency room visits.^{48,49}

In recognition of the potential of telepsychiatry, the New Jersey Department of Human Services is reimbursing telepsychiatric services to directly address the shortage of mental health care access.⁵⁰

⁴⁷ Economic Evaluation in Telemedicine – Still Room for Improvement; Bergmo TS et al.; Journal of Telemedicine Telecare 16.5 (2010): 229-31. DOI: 10.1258/jtt.2010.009008

⁴⁸ Telehealth and Health Care Provider Shortages. American telemedicine Association Position Statement. American Telemedicine Association (2007).

⁴⁹ Acute Illness Care Patterns Change with Use of Telemedicine; McConnochie KM, et al.; Pediatrics 2009 123.6: 989–995

⁵⁰ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services Newsletter; vol 23:21; December 2013 at <http://www.njha.com/media/292399/Telepsychiatrymemo.pdf>

Recommendations

Recommendations by the New Jersey Psychiatric Association and the Regional Council of Child & Adolescent Psychiatrists:

1. Ensure a high minimum standard of care consistent with the guidelines set forth by the American Psychiatric Association (APA)⁵¹, the American Academy of Child and Adolescent Psychiatrists (AACAP)⁵² and the American Telemedicine Association (ATA)^{53,54} and the New Jersey Department of Human Services⁵⁵. These include, but are not limited to:
 - a. Maintain confidentiality and adhering to the standards set forth by HIPAA and HI-TECH,
 - b. Obtain consent from patients and/or guardians after being clearly informed of the nature of telepsychiatry services,
 - c. Establish proper procedures and training for staff at the site where the patient is located, including emergency protocols,
 - d. Require a currently valid New Jersey medical license and federal DEA registration from prescribing practitioners,
 - e. Sustain the bandwidth capacity (at least 384 Kbps) to maintain a high quality video link between the provider and patient, and
 - f. Meet all applicable federal and state regulations for the practice of medicine;
2. Increase broadband capability of rural or other underserved areas;
3. Improve reimbursement from government and commercial payers;
4. Update regulations of telemedicine including removal of outdated regulatory barriers;
5. Encourage use of telepsychiatry in underserved care centers with patients, physicians and other healthcare providers where direct physician-patient contact is not feasible.

⁵¹ American Psychiatric Association resource document 980021, April 1998

⁵² American Academy of Child and Adolescent Psychiatry. Practice parameters for Telepsychiatry with Children and Adolescents. *Journal of the American Academy of Child Adolescent Psychiatry*, 47:12, Dec 2008: 1468-1483.

⁵³ American Telemedicine Association Practice Guidelines for Video-Conferencing Based Mental Health, October 2009

⁵⁴ American Telemedicine Association Practice Guidelines for Video-Based Online Mental Health Services, May 2013

⁵⁵ State of New Jersey Department of Human Services, Division of Medical Assistance & Health Services Newsletter; vol 23:21; December 2013 at <http://www.njha.com/media/292399/Telepsychiatrymemo.pdf>