REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

STUDY OF REIMBURSEMENT AND QUALITY OF CARE ISSUES REGARDING TELEMEDICINE PURSUANT TO HJR 210

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 48

COMMONWEALTH OF VIRGINIA
RICHMOND
1999

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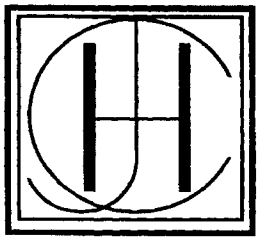

Preface

House Joint Resolution (HJR) 210 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care to study reimbursement and quality of care issues related to telemedicine.

Telemedicine is defined as "the use of telecommunications technology to deliver health care services and health professions education to sites that are distant from the host site or educator." A number of state agencies are currently engaged in telemedicine initiatives. These include: the Department of Corrections, the Medical College of Virginia, the University of Virginia Health Sciences Center, the Department of Mental Health, Mental Retardation, and Substance Abuse Services, and the Department of Health.

Based on our research and analysis, we concluded the following:

- Limited third party reimbursement is one obstacle to the growth of telemedicine;
- Third party payors are willing to pay for telemedicine services they deem cost-effective and capable of providing quality care;
- The Commonwealth can play a role in encouraging third party reimbursement for telemedicine services by using its own telemedicine projects as pilot projects to demonstrate the cost effectiveness and quality of care offered by various telemedicine services;
- The need exists for some coordination among state agencies to ensure that telemedicine equipment purchased by state agencies is compatible; and
- The Commissioner of Health should play a role in monitoring the state's progress in telemedicine initiatives and the extent to which these initiatives have increased access to care in medically underserved areas of the Commonwealth.

A number of policy options were offered for consideration by the Joint Commission on Health Care regarding the issues discussed in this report. These policy options are listed on pages 14-15.

Our review process on this topic included an initial staff briefing, which comprises the body of this report. This was followed by a public

comment period during which time interested parties forwarded written comments to us regarding the report. These public comments, which are provided in Appendix C, provide additional insight into the various issues covered in this report.

Patrick W. Finnerty
Executive Director

February 3, 1999

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I.
Authority for the Study

House Joint Resolution (HJR) 210 of the 1998 Session of the General Assembly directed the Joint Commission on Health Care, in consultation with the Department of Health and the Department of Medical Assistance Services, to examine quality of care and reimbursement issues related to telemedicine. Specifically, HJR 210 directs the Joint Commission to examine: (i) the experience of other states with regard to reimbursement for telemedicine services and options for the Commonwealth in developing such reimbursement policy; (ii) what services can be cost-effectively and efficiently provided through telemedicine for which Medicaid reimbursement is appropriate; and (iii) the appropriate role for the Department of Health in identifying medically underserved areas of the Commonwealth in which telemedicine services could expand access to health care. The Joint Commission was directed to complete its work in time to submit its findings and recommendations to the 1999 Session of the General Assembly.

A copy of HJR 210 is provided at Appendix A.

II.
Introduction

The Joint Commission on Health Care last examined telemedicine issues in a 1996 report: *Study of Telemedicine Pursuant to HJR 455 of 1995.* The Joint Commission on Health Care's 1996 report on telemedicine (HD 6) defines telemedicine as "the use of telecommunications technology to deliver health care services and health professions education to sites that are distant from the host site or educator." As HD 6 pointed out, telemedicine applications take a variety of forms, ranging from relatively inexpensive technology such as videophones (costing less than $1,000) to sophisticated sites costing more than $100,000. Appendix B profiles selected telemedicine sites in Virginia.

Specific applications of telemedicine include, but are not limited to:

- the use of imaging technology to send radiology images from a remote site to be read;
- a telemedicine link between an academic health sciences center and a correctional institution's infirmary where physicians and other health care providers can deliver services typically conducted in outpatient clinics;
- a telemedicine link between a psychiatrist at one site and a patient at a different, remote site during which psychiatric counseling or medication management/monitoring services are rendered by the physician;
- a videophone link between a health care provider and a home bound patient where the provider can use the videophone link to monitor medications or check to see if the patient is able to perform certain self-care activities such as dressing.

One policy option presented by the 1996 JCHC study on telemedicine was for the General Assembly to request the Secretary of Administration and the Secretary of Education to develop a policy for considering reimbursement for telemedicine services by state health programs (primarily the inmate health care program provided by the Department of Corrections, the Medicaid program and the State Employee Health Benefits Program administered by the Department of Personnel and Training). At the direction of the 1997 General Assembly, the Secretaries of Administration and Education completed a study of telemedicine reimbursement by state programs (published in 1997 as two reports: HD 31 and HD 51). This study was led by the Council on Information Management.

While the study yielded several recommendations, a consensus was not reached regarding telemedicine reimbursement through state programs. In

particular, representatives of the Department of Personnel and Training and Trigon (the primary health benefits carrier for state employees) expressed concern about mandating a single policy for reimbursement, preferring to leave such decisions up to the individual agencies administering the programs.

Depending on the payor source and the location of the patient, telemedicine offers a range of potential opportunities for cost savings and increased access. With regard to correctional health care, the opportunities for cost savings in telemedicine are perhaps greatest, because telemedicine potentially allows the payor (for example the state Department of Corrections) to avoid both transportation costs and security costs associated with moving inmates with medical care needs from a correctional facility to a distant site such as an academic health sciences center (for example an inmate from Powhatan Correctional Center being transported to be treated at the Medical College of Virginia Hospitals in Richmond). With respect to Medicaid, telemedicine offers potential cost savings, because the Medicaid program pays for patient transportation. Telemedicine potentially can reduce or eliminate transportation costs associated with a Medicaid recipient traveling from home to a distant health care provider (for example a Medicaid recipient from Norton, Virginia traveling to be treated in an outpatient specialty clinic at the University of Virginia Health Sciences Center in Charlottesville).

The potential for health care payor cost savings related to telemedicine is less certain with patients who have third party insurance coverage. Unlike Medicaid, third party insurance payors typically do not pay for patient transportation costs. Therefore the cost savings associated with reduced transportation costs would accrue to the patient, not the payor, because the patient is responsible for transportation expenses in the first place. However, for the very reason that patients typically incur the costs of transportation (including lost wages and dependent care expenses), telemedicine has the potential to increase access to health care services for residents of medically underserved areas.

This report is divided into six sections. The first section discussed the authority for the study. This section has provided a general overview of telemedicine and past study efforts related to telemedicine. The third section discusses the experiences of other states and the federal government with telemedicine. The fourth section discusses telemedicine's potential for the Medicaid program. The fifth section discusses the role of the Virginia Department of Health with regard to increasing access to health care services through telemedicine. Finally, the conclusion identifies (i) other issues related to telemedicine that are important for state policy makers, and (ii) policy options concerning telemedicine.

III.
Experiences of Other States and the Federal Government With Telemedicine Reimbursement

Most states have not yet addressed telemedicine reimbursement in their state insurance laws and regulations. However, four states: California, Louisiana, Oklahoma, and Texas have passed insurance statutes regarding telemedicine reimbursement by third party payors. Each of these is discussed below. In addition, the U.S. Health Care Financing Administration (HCFA) has been exploring Medicare reimbursement for telemedicine services for several years. Congress recently mandated that HCFA begin offering Medicare reimbursement for certain telemedicine services in medically underserved areas in 1999.

The California statute, § 1374.13 of the California Health and Safety Code states: "On and after January 1, 1997, no health care service plan contract that is issued, amended, or renewed shall require face-to-face contact between a health care provider and a patient for services appropriately provided through telemedicine." The statute adds that "health care service plans shall not be required to pay for consultation provided by the health care provider by telephone or facsimile machines." It is important to note that this statute specifies "services appropriately provided through telemedicine" as opposed to all services. A similar California statute, § 10123.85 of the California Insurance Code applies to disability insurers.

The Louisiana statute (Louisiana Revised Statutes Annotated 22:657) states: "Terminology in a health and accident insurance policy or contract that discriminates against or prohibits such a method of transmitted electronic imaging or telemedicine shall be void as against public policy of providing the highest quality health care to the citizens of the state." The statute also provides that telemedicine services must be reimbursed at no less than 75 percent of the amount typically paid for face-to-face service delivery. The statute also makes telemedicine services subject to the normal utilization review procedures of the insurance carrier.

The Oklahoma statute regarding telemedicine (Title 36, § § 6801 to 6804) states: "For services that a health care practitioner determines to be appropriately provided by means of telemedicine, health service plans, disability insurer programs, workers' compensation programs, or state Medicaid managed care program contracts issued, amended, or renewed on

January 1, 1998, shall not require person-to-person contract between a health care practitioner and a patient." This statute also requires physicians to obtain informed consent from patients prior to telemedicine services being delivered.

The Texas statute (Texas Insurance Code Annotated Article 21.53 F) defines telemedicine as "the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile machine." The statute further states that a health benefit plan may not exclude a service from coverage under the plan solely because the service is provided through telemedicine and not provided through a face-to-face consultation.

In addition to the statutes approved in the four states discussed above, Mississippi and Hawaii have considered similar legislation. Both states considered but did not enact statutes requiring reimbursement of telemedicine services during the 1998 legislative session.

Just as state action regarding telemedicine reimbursement has accelerated since the Joint Commission's 1996 report on telemedicine, so has the federal policy towards reimbursement for Medicare. At present, HCFA is completing a four-state demonstration project for Medicare to determine the effectiveness of telemedicine delivery of specialist consultation services. The states participating in the demonstration project are: Georgia, North Carolina, West Virginia, and Iowa. The project was initiated in 1996, and HCFA expects to have completed the project by 2000.

While HCFA's study of Medicare telemedicine reimbursement is ongoing, the Balanced Budget Act of 1997 requires the Medicare program to begin reimbursing physicians for telemedicine consultation services in federal fiscal year 1999. This requirement is limited to 1,200 "health professional shortage areas" nationwide, of which 35 are in Virginia. A telemedicine session eligible for reimbursement under this provision is defined as "consultation between a Medicare beneficiary's physician and a consulting physician."

IV.
Telemedicine and the Virginia Medicaid Program

At present, the decision to offer reimbursement for telemedicine services is left to the individual states by the U.S. Health Care Financing Administration (HCFA). At present, Virginia is one of 11 states that provides for some level of reimbursement for telemedicine services through the Medicaid program, administered by the Department of Medical Assistance Services (DMAS). These states are shown in Table 1.

Table 1
States Providing Medicaid Reimbursement for Telemedicine Services

State	Services Reimbursed
Arkansas	physician consultation
California	physician consultation (medical and mental health)
Georgia	physician consultation
Illinois	physician consultation
Iowa	physician consultation (supplementary payment for scheduling and technical support expenses)
Kansas	certain home health and mental health services
Montana	any medical or psychiatric service already covered by the state plan
North Dakota	specialty physician consultation
South Dakota	physician consultation
Virginia	physician consultation, mental health medication monitoring
West Virginia	physician consultation

Source: U.S. Health Care Financing Administration.

As can be seen from Table 1, physician consultation is the service most typically covered by state Medicaid programs for telemedicine. At present, the Virginia Medicaid program provides reimbursement for physician consultation with the local physician of Medicaid recipients from two sites: the University of Virginia Health Sciences Center and the Medical College of Virginia Hospitals. Both the consulting physician at the academic health sciences center and the treating physician in the community are eligible to receive reimbursement (the amount of which is determined by the CPT code billed for the consultation). The amount of reimbursement provided is the same as if the consultation were conducted face-to-face.

In addition to physician consultation, the Virginia Medicaid program currently covers telepsychiatry services for patients discharged from Southwest Virginia Mental Health Institute in Marion. Staff physicians at the mental health institute are able to monitor medication usage for patients recently discharged from inpatient care. This is the only telepsychiatry service presently reimbursed by the Virginia Medicaid program. However, DMAS is currently planning to allow Medicaid for certain telebehavioral services provided by the District 19 Community Services Board, based in Petersburg.

Table 2 lists the providers currently eligible to receive reimbursement for telemedicine services in Virginia. It is important to note that, in the case of physician consultation with the University of Virginia Health Sciences Center or the Medical College of Virginia Hospitals, the treating physician of the Medicaid recipient is also eligible to receive reimbursement for the consultation.

Table 2
Providers Currently Eligible to Receive Medicaid Reimbursement for Selected Telemedicine Services

Provider	Telemedicine Services Reimbursed Through Medicaid
University of Virginia Health Sciences Center	Physician Consultation
Medical College of Virginia Hospitals	Physician Consultation
Southwest Virginia Mental Health Institute/Cumberland Mountain Community Services	Medication Monitoring

Source: Department of Medical Assistance Services

Telemedicine is a potentially cost effective means for delivering certain medical services in the Medicaid program, because, as noted earlier, the Medicaid program pays for transportation of patients, in addition to the medical care provided. In FY 1997, the Virginia Medicaid program's transportation expenses totaled approximately $35.5 million in FY 1997, compared to approximately $21.5 million in 1993, according to the *Statistical Record of the Virginia Medicaid Program.* While telemedicine does not have the potential to eliminate all of Medicaid's transportation expenditures, it does have the potential to reduce these expenditures.

During a structured interview with Joint Commission on Health Care staff, the telemedicine contact from DMAS indicated that the agency needs to evaluate its telemedicine coverage once a sufficient volume of claims has been submitted. If the evaluation results are positive, DMAS is interested in expanding its involvement in telemedicine. If DMAS was to expand telemedicine coverage, protocols would need to be developed to address areas such as documentation of services and confidentiality of information.

V.
The Role of the Virginia Department of Health in Telemedicine

Item 319 #1c of the 1998 Appropriation Act provided funds for the Virginia Department of Health (VDH) to "expand telemedicine capabilities in three local health departments." This appropriation included (i) three full-time equivalent positions in each year of the biennium, (ii) $647,623 (GF) in the first year of the biennium, and (iii) $140,808 (GF) in the second year of the biennium.

VDH selected three sites for this program: Lancaster County, Lee County, and the City of Danville. VDH expects approximately a six-month start-up time before the sites are ready to treat patients in the Spring of 1999. Each site will be staffed with one full-time public health nurse position funded by the telemedicine appropriation.

VDH currently views the three telemedicine sites as an opportunity to increase access to specialty and sub-specialty care for residents of medically underserved regions of the Commonwealth. As VDH does not currently have specialist physicians on staff, (most VDH physicians have primary care and/or preventative medicine training), VDH expects that the specialty and sub-specialty treatments will be provided at each site via telemedicine by physicians from one of the state's three academic health sciences centers: the University of Virginia, the Medical College of Virginia, and Eastern Virginia Medical School.

The addition of telemedicine services to three local health departments offers the Commonwealth an opportunity to study the cost-effectiveness and quality of care offered by various specialty and sub-specialty providers using telemedicine. This information could be useful in assessing the advisability of third party insurers offering telemedicine reimbursement.

VI.
Conclusion and Policy Options

Telemedicine is now an issue that potentially impacts a number of state agencies. These include: the University of Virginia Health Sciences Center; Virginia Commonwealth University's Medical College of Virginia Hospitals; the Department of Medical Assistance Services; the Department of Corrections; the Department of Health; the Department of Personnel and Training; the Department of Health Professions; the Department of Information Technology; the Council on Information Management; and the Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).

One potential concern that will potentially emerge as more state agencies move into the delivery of telemedicine services is the compatibility among telemedicine equipment purchased by the state. At present, there is no central coordinating entity to ensure compatibility of equipment and a minimum standard for the specifications of equipment used to deliver telemedicine services. While much has been accomplished through informal coordination, it may be useful to assign a formal coordinative role to the Governor's newly appointed Secretary of Technology. Similarly, it would be appropriate for the Commissioner of Health to assume a lead role in coordinating the use of telemedicine to improve access to quality health care in medically underserved areas and to report annually on progress in attaining this objective.

Another area where some coordination would be appropriate is in the licensure area. Various states have taken a range of actions in regulating and licensing telemedicine providers (particularly those from other states). At present, it is not clear that Virginia's regulatory boards are going to be able to take a consistent approach to this issue. In September 1997, at the request of the Director of the Department of Health Professions, the Board of Health Professions formed an ad hoc task force on telemedicine that is expected to issue its final report in the Fall of 1998.

The Board of Health Professions recently voted that, for purpose of licensure, telemedicine services should be deemed to take place where the patient is located. The Board also voted to pursue both a multi-state compact and requiring a limited telemedicine license. However, regulatory action has yet to be taken by the professional regulatory boards within the Department, such as the Board of Nursing and the Board of Medicine. Discussion among board members suggested that what may be an appropriate policy option for nursing licensure (for example a multi-state compact) may not be appropriate for

physician licensure (as other states have already rejected the multi-state compact notion in favor of requiring at least a limited license within that state).

The area of licensure may be an area where further legislative guidance is needed. The General Assembly may wish to address where it defined a telemedicine service to have occurred for purposes of licensure (at the site of the patient or the site of the provider) and the General Assembly's policy preference regarding a licensure approach (multi-state compact, limited licensure, full licensure, or some combination of these options).

While out-of-state licensure issues remain unresolved, the growth of telemedicine has continued since the Joint Commission on Health Care's last report on telemedicine. As Medicare and a growing number of states through Medicaid are poised to offer reimbursement for telemedicine services, this availability of third party payment should further spur the growth of telemedicine. However, the acceptance by private insurers of telemedicine services as appropriate for reimbursement remains uneven and relatively rare. One possible role for the state in encouraging private third party payors to reimburse for telemedicine services is to use state health programs, where appropriate, as demonstration projects for documenting the medical efficacy and cost effectiveness of telemedicine. This potential role for the state, as well as opportunities for enhanced coordination of telemedicine issues, is addressed by the policy options below.

Option I: **Take No Action**

Option II: **Introduce legislation requiring the Secretary of Technology to establish and regularly update guidelines for: (i) setting minimum specifications for telemedicine equipment purchased by agencies of the Commonwealth or using state funds, and (ii) ensuring compatibility among the telemedicine networks established by state agencies.**

Option III: **Introduce a budget amendment providing funds for the Department of Health to conduct an evaluation of the quality of care and cost effectiveness of telemedicine service delivered at the three local health department sites receiving funds provided in the 1998 Appropriation Act.**

Option IV: **Introduce legislation directing the Commissioner of Health to report annually to the Joint Commission on Health Care regarding the implementation of telemedicine initiatives in the Commonwealth and the extent to which telemedicine is (i)**

increasing access to care in medically underserved areas of the Commonwealth, and (ii) providing quality care.

Option V: Introduce a budget amendment providing funds to the Department of Personnel and Training to establish a telemedicine demonstration project for the State Employee Health Benefits Program to reimburse specialty and subspecialty consultations for state employees in a selected planning district. This budget amendment would also include language directing that an evaluation be conducted of the medical efficacy and cost effectiveness of these services.

Option VI: Introduce legislation providing guidance to the Department of Health Professions and its related regulatory boards concerning legislative intent regarding licensure of telemedicine providers.

Option VII: Introduce a budget amendment directing the Department of Medical Assistance Services to (i) evaluate the results of its telemedicine reimbursement, (ii) develop protocols to address documentation of services and confidentiality of patient information, and (iii) identify additional services for which telemedicine reimbursement would be cost effective and medically appropriate.

APPENDIX A

Appendix A

HOUSE JOINT RESOLUTION NO. 210

Directing the Joint Commission on Health Care, in cooperation with the Departments of Health and Medical Assistance Services, to conduct a study of quality of care and reimbursement issues related to telemedicine.

Agreed to by the House of Delegates, February 17, 1998
Agreed to by the Senate, March 10, 1998

WHEREAS, telemedicine is an emerging technology for the delivery of certain health care services; and

WHEREAS, the Department of Corrections is currently using telemedicine to deliver certain specialty services to inmates; and

WHEREAS, the Joint Commission on Health Care examined telemedicine issues in a 1995 study, published in 1996 as House Document 6; and

WHEREAS, a 1997 executive branch study was unable to reach consensus regarding telemedicine reimbursement for state programs; and

WHEREAS, health care payors have expressed concern that telemedicine has not yet been proven to deliver quality care and that routine reimbursement for telemedicine services may increase health care costs; and

WHEREAS, telemedicine potentially could improve access to health care in rural areas; and

WHEREAS, Virginia's academic medical centers have been active in investigating applications for telemedicine; now, therefore, be it

RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care, in cooperation with the Departments of Health and Medical Assistance Services, be directed to conduct a study of quality of care and reimbursement issues related to telemedicine. The study shall include, but not be limited to, an examination of (i) the experience of other states with regard to reimbursement for telemedicine services and options for the Commonwealth in developing such reimbursement policy; (ii) what services can be cost-effectively and efficiently provided through telemedicine for which Medicaid reimbursement is appropriate; and (iii) the appropriate role for the Department of Health in identifying medically underserved areas of the Commonwealth in which telemedicine services could expand access to health care.

All agencies of the Commonwealth shall provide assistance to the Joint Commission and its staff for this study, upon request.

The Joint Commission shall complete its work in time to submit its findings and recommendations to the Governor and the 1999 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

APPENDIX B

Appendix B
Selected Telemedicine Sites in Virginia

Virginia Commonwealth University Medical College of Virginia Hospitals and Blackstone Family Practice

VCU-MCV is working with the Blackstone Family Practice Center in Blackstone, Virginia to provide specialty services to patients and health professions education to medical students, residents, and practitioners. Funding sources for the project included $75,000 from the Higher Education Equipment Trust Fund and $125,000 from the University of the 21st Century Fund.

Virginia Commonwealth University-Medical College of Virginia and the Department of Corrections

At the direction of the 1994 General Assembly, VCU-MCV has developed a telemedicine program at Powhatan Correctional Center that serves a number of Department of Corrections (DOC) institutions located near Powhatan. The 1995 General Assembly approved $150,000 to support the project. The project provides a range of specialty services to inmates.

University of Virginia Health Sciences Center and the Department of Corrections

The University of Virginia Health Sciences Center's Office of Telemedicine has developed telemedicine links with six DOC institutions and the Department of Corrections Headquarters (the headquarters telemedicine link is in the DOC chief physician's office). Inmates are able to receive outpatient specialty services through telemedicine consultations. Services include hepatology, cardiology, infectious disease, dermatology, ENT, orthopedics, and neurology.

Southwest Virginia Alliance for Telemedicine

This project is partially funded by a U.S. Department of Commerce grant. The project links UVA to the Lee County Community Hospital in Pennington Gap, Norton Community Hospital, the Thompson Family Health Center in Vansant, and the Stone Mountain Health Services Clinic in Castlewood. UVA providers can deliver specialty services to patients at any of these sites. The project recently received a grant from the Virginia Health Care Foundation.

Appal-Link Telepsychiatry Network (Previously the Southwest Virginia Telepsychiatry Network)

Appal-Link is a cooperative effort among Cumberland Mountain Community Services, Southwest Virginia Mental Health Institute, and other cooperating community services

boards. Appal-Link currently encompasses nine network sites covering 20,000 square miles. The project was originally funded in the fall of 1994 by a three-year grant from the Office of Rural Health Policy. The project has also received financial support from the Department of Mental Health, Mental Retardation, and Substance Abuse Services. The project is the only telepsychiatry project currently receiving Medicaid reimbursement (for medication monitoring only) in Virginia.

Eastern Virginia Telemedicine Network

The Eastern Virginia Telemedicine Network is a health professions distance learning, teleconsultation, and clinical telemedicine network established by Eastern Virginia Medical School (EVMS) and the Eastern Shore Rural Health System, Inc. Funding for the project has been received from the Virginia Health Care Foundation, EVMS, and the Eastern Virginia Area Health Education Center. The network will allow participating institutions to link with the Norfolk campus of EVMS for health professions education and delivery of telemedicine services.

APPENDIX C

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS: TELEMEDICINE STUDY (HJR 210)

Individuals/Organizations Submitting Comments

A total of four individuals and organizations submitted comments in response to the HJR 210 report on telemedicine.

Cumberland Mountain Community Services
Medical College of Virginia Campus of Virginia Commonwealth University
Virginia Association of Community Services Boards
Virginia Hospital and Healthcare Association

Policy Options Included in the HJR 210 Issue Brief

Option I: **Take No Action**

Option II: **Introduce legislation requiring the Secretary of Technology to establish and regularly update guidelines for: (i) setting minimum specifications for telemedicine equipment purchased by agencies of the Commonwealth or using state funds, and (ii) ensuring compatibility among the telemedicine networks established by state agencies.**

Option III: **Introduce a budget amendment providing funds for the Department of Health to conduct an evaluation of the quality of care and cost effectiveness of telemedicine service delivered at the three local health department sites receiving funds provided in the 1998 Appropriation Act.**

Option IV: **Introduce legislation directing the Commissioner of Health to report annually to the Joint Commission on Health Care regarding the implementation of telemedicine initiatives in the Commonwealth and the extent to which telemedicine is (i) increasing access to care in medically underserved areas of the Commonwealth, and (ii) providing quality care.**

Option V: **Introduce a budget amendment providing funds to the Department of Personnel and Training to establish a telemedicine demonstration project for the State Employee Health Benefits Program to reimburse specialty and subspecialty consultations for state employees in a selected planning district. This budget amendment would also include language directing that an evaluation be conducted of the medical efficacy and cost effectiveness of these services.**

Option VI: **Introduce legislation providing guidance to the Department of Health Professions and its related regulatory boards concerning legislative intent regarding licensure of telemedicine providers.**

Option VII: **Introduce a budget amendment directing the Department of Medical Assistance Services to (i) evaluate the results of its telemedicine reimbursement, (ii) develop protocols to address documentation of services and confidentiality of patient information, and (iii) identify additional services for which telemedicine reimbursement would be cost effective and medically appropriate.**

Overall, the comments received were generally positive. To the extent that there was disagreement among the public comments, this disagreement focused on Option II (setting standards for equipment) and Options VI (providing guidance on legislative intent regarding licensure of telemedicine providers).

Cumberland Mountain Community Services

Ronald A. Allison, Executive Director of Cumberland Community Services, commented that his organization supported the comments made by the Virginia Association of Community Services Boards (see below). Mr. Allison added that his organization would like to make some specific comments. Mr. Allison commented in favor of Option II, stating it "should be immediately implemented." Mr. Allison added, "If we choose to use this technology to benefit mental health consumers, then it should certainly be first and foremost be as effective as possible. We do not consider some systems in Virginia to be within acceptable standards of practice." . Mr. Allison also stated that Medicaid and private insurance alone would never be able to pay the entire cost of building a statewide telemedicine network. In his view, some type of special pooling of funds created by the state would be necessary. Arizona was pointed to as a good model in this regard.

Medical College of Virginia, Virginia Commonwealth University

Hermes A. Kontos, M.D., Ph.D., Vice President for Health Sciences and Dean of the School of Medicine, Medical College of Virginia Campus, Virginia Commonwealth University, commented that instead of using the term "telemedicine," the term "telehealth" should be employed to reflect the broad usage of telecommunications technology in "education and research in addition to direct care." Dr. Kontos commented in support of Option V, and expressed opposition to Option II. With regard to Option II, Dr. Kontos stated "this technology is changing so rapidly that it would be difficult to set minimum specifications that could be kept current. We believe it would be counterproductive to establish specifications for equipment and networks at present."

Virginia Association of Community Service Boards

Mary Ellen Bergeron, Executive Director of the Virginia Association of Community Services Boards, opposed Option I (take no action). Ms. Bergeron commented in favor of Options II, V, and VII. Ms. Bergeron added that Option IV "should be accomplished and should be a priority for the Joint Commission." She stated "Option III is fine, but only if there are goals attached to such a study." Ms. Bergeron stated "Option IV could be done if part of a long range reimbursement plan." Ms. Bergeron opposed

Option VI at present, stating "We suggest this option be held until legislative intent regarding licensure of telemedicine provider[s] is formulated."

Ms. Bergeron closed her comments by pointing out the need for "a plan for providing both telemedicine and telepsychiatry services to those persons who are deaf and hearing-impaired." She added that "our Association believes strongly that telemedicine and/or telepsychiatry services should be reimbursed."

Virginia Hospital and Health Care Association

Katharine M. Webb, Senior Vice President of the Virginia Hospital and Health Care Association (VHHA), commented in favor of Options III, IV, V, and VII, stating "these options provide opportunities to evaluate the effectiveness of telehealth and can guide us in developing appropriate regulation." Ms. Webb stated that "VHHA supports Option II, to the extent that the state ensures compatibility among state agencies' telehealth networks. We believe that setting minimum specifications by law for equipment may be a barrier to use of rapidly advancing technology."

Ms. Webb stated that VHHA opposes Option VI, stating "that there is currently no agreement on what that guidance should be." She added that legislative guidance in the future may be appropriate, but that any regulatory framework for telehealth should be developed with a national perspective to provide uniformity, "so as not to unfairly penalize providers or patients who may benefit from these services."

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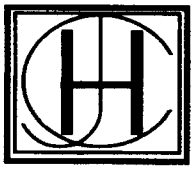

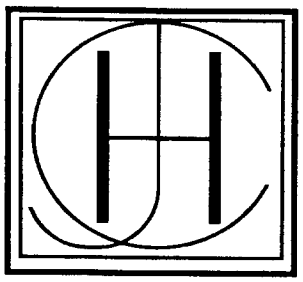

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