

Testimony from Dr. Terry Rabinowitz – S.50
House Health Care Committee
3.29.17

Overview of perspective on S.50:

- When looking at the Triple Aim, telemedicine has the potential to:
 - Increase access, particularly for hard to recruit for specialty services
 - Increase quality and patient satisfaction , particularly for underserved parts of the region – including New York
 - Studies on patient satisfaction have shown almost universally that patients who are able to receive care using telehealth modalities are generally pleased with their experiences and outcomes.
 - In terms of the effectiveness of telehealth for specific clinical conditions, AHRQ’s Evidence Map suggests there are four particular areas where telehealth has distinct promise. These include behavioral health, dermatology, chronic disease management (e.g., cardiovascular conditions, respiratory disease, diabetes, and stroke), and physical rehabilitation.

From REPORT TO CONGRESS, August 12, 2016 E-health and Telemedicine U.S. Department of Health and Human Services
 - Reduce costs, by ensuring timely treatment, reducing likelihood of unnecessary ED and hospital admissions and duplication of expensive specialists
- Three trends, all linked, are currently shaping telehealth. The first is the transformation of the application of telehealth from increasing access to health care to providing convenience and eventually reducing cost. The second is the expansion of telehealth from addressing acute conditions to also addressing episodic and chronic conditions. The third is the migration of telehealth from hospitals and satellite clinics to the home and mobile devices.
- As the United States moves from uncoordinated, volume-based delivery of health services to an integrated, patient-centric, value-based model, health care delivery will increasingly focus on achieving higher-quality care, improved care access, and lower costs. In enabling health care organizations to provide high-quality, “anytime, anywhere” care to patients and operate more cost effectively, telehealth programs can play an important role in achieving these goals.

Health Policy Brief , Robert Wood Johnson, August 15, 2016

As of August 2016:

- **48** state Medicaid programs and DC are now reimbursing for live video telehealth.
- **12** state Medicaid programs offer some reimbursement for store-and-forward, not counting states that only reimbursed for tele-radiology. (two policies are not yet effective)
- **19** state Medicaid programs reimburse for remote patient monitoring. Three policies go into effect at a later date.
- **30** state Medicaid programs offer a transmission or facility fee when telehealth is used.
- **29** states require a telehealth specific informed consent be obtained from the patient in their statute, administrative code and/or Medicaid policies.
- **34** states and DC now have active laws that govern private payer telehealth reimbursement policies. Two of the policies are not yet effective.
- **9** states have some form of geographic requirement, restricting telehealth reimbursement to rural or underserved areas, or require a certain amount of distance between an originating and distant site.
- **25** states limit reimbursement to a specific list of facilities, with **10** adding such a list to their policy in the past nine months.
- **9** state medical boards issue licenses related to telehealth, while **17** states have adopted the Interstate Medical Licensure Compact, which is an expedited licensure process.

From Center for Connected Health Policy

<http://www.cchpca.org/state-telehealth-laws-and-reimbursement-policies-report>

Specific suggestions for S.50

We support the amendment made by the Senate to redefine “in” and “outside” of a health care facility. The use of “distant” and “originating” site language is much more clear.

Page 1; Section 1; Subsection (a)

We are concerned that “to the same extent” in this context could be interpreted in a number of ways, and believe it refers to, not only plan coverage, but also reimbursement to providers. As it relates to reimbursement – an important part of the equation for providers considering whether to begin providing services through telemedicine – we recommend adding language from Hawaii’s legislation:

Reimbursement for services provided through telehealth shall be equivalent to reimbursement for the same services provided via face-to-face contact between a health care provider and a patient. Nothing in this section shall require a health care provider to be physically present with the patient at an originating site unless a health care provider at the distant site deems it necessary.

Page 2; Section 1; Subsection (c)

The language around the potential for requirements for documentation on the appropriateness of providing services through telemedicine versus face-to-face consultations provided assurances in 2012, but given the mounting body of literature indicating the efficacy of telemedicine, we believe is no longer necessary. The question we would ask is: either the service is or is not medically indicated. Beyond that, special requirements for documentation are unnecessarily burdensome. We would suggest striking that language.

Page 2; Section 1; Subsection (e)

The result of having “may reimburse” included in the Act 107 has been that carriers have elected to not include coverage for store and forward. While we believe coverage would be both medically-appropriate and would alleviate significant access problems for a hard-to-recruit-for specialty in Vermont, we are more concerned about the inconsistencies that could arise from some carriers choosing to elect to cover the services and others choosing not to. While we would prefer requiring coverage, if the Legislature chooses not to do that, we would ask that the section be eliminated.

We support the amendment made by the Senate to include additional disciplines, including occupational therapists, physical therapists, speech language pathologists, and licensed dieticians.