

Telemedicine and Telehealth: Putting the Pieces Together



**Executive Summary and Recommendations
based on January 9, 2012 Roundtable Discussion**



Prepared by the
Legislative Commission on Rural Resources
in cooperation with the
Senate and Assembly Health and Insurance Committees

March 2012

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Dear Friend,

In response to interactions with and recommendations from the health care community and all those it serves, the Legislative Commission on Rural Resources – in conjunction with the Senate and Assembly Health and Insurance Committees – sponsored a telehealth/telemedicine roundtable on January 9, 2012, "Telehealth and Telemedicine: Putting the Pieces Together."

The roundtable brought together leading experts representing all facets of the health care field, from home care to telepsychiatry to niche markets – all with the goal of identifying barriers to the implementation of a statewide telehealth network, while simultaneously highlighting successes and working models.

This document will examine highlights from the roundtable and make some initial recommendations for legislative and other action. The complete video of the event is available at the Legislative Commission on Rural Resources' website, which may be accessed at:

<http://www.nysenate.gov/event/2012/jan/09/telehealthtelemedicine-roundtable-0>

The Chairs wish to thank all participants for their input, and we look forward to our continued work on advancing telehealth/telemedicine initiatives in 2012.

Sincerely,



Senator Catharine M. Young
Chair



Assemblywoman Aileen M. Gunther
Vice Chair



CONTENTS

Introductory Letter	1
List of Roundtable Participants	4
Summary	
Background	7
Definitions of Telehealth and Telemedicine	8
Recent MRT Efforts	9
Existing Statewide Programs and Successes	10
Problems/Barriers	13
Recommendations	19
2012 Enacted State Budget	21
Appendices A - J	23

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Commission on Rural Resources

Assemblywoman Aileen Gunther
Vice Chair
Commission on Rural Resources

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Senator Patricia Ritchie
Senator Neil Breslin
Senator Timothy Kennedy

Assemblywoman Barbara Lifton
Assemblyman Daniel Burling
Assemblyman Philip Palmesano

Senator David Valesky, Ex-Officio Member/Special Advisor
Commission on Rural Resources

Senator Kemp Hannon
Chair, Senate Committee on Health

Senator James Seward
Chair, Senate Committee on Insurance

Assemblyman Richard Gottfried
Chair, Assembly Committee on Health

Assemblyman Joseph Morelle
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Vice President for Regulatory Affairs
Healthcare Association of NYS

Alexis Silver
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Home Care Association of NYS

Mary Ann Zelazny, BA
Chief Executive Officer
Finger Lakes Migrant Health
Penn Yan

Victoria Hines, MPH
President and Chief Executive Officer
Visiting Nurse Service of Rochester
and Monroe County, Inc.

Cynthia Gordon, RN, MSN
(via teleconference)
Director of Telehealth Services
Rochester General Health System and
InterVol

SUMMARY

Background

In January 2012, the Legislative Commission on Rural Resources, in conjunction with the Senate and Assembly Health and Insurance Committees, convened a roundtable in Albany, New York. The event, "Telehealth and Telemedicine: Putting the Pieces Together," brought together various experts from the healthcare community to discuss telehealth/telemedicine programs, challenges and recommendations for bringing these much needed and proven services to New York State's unserved and underserved communities.

In light of the Governor's Medicaid Redesign Team directive to reduce state health care expenditures – and recognizing the necessity of broadband technology to link a Statewide network of telehealth/telemedicine services which meet patients' health care needs – the Commission presented questions to roundtable participants as the basis for discussion:

1. What are the legislative barriers to implementing a Statewide telehealth/telemedicine network given New York State's current reimbursement structure and regulatory and fiscal environment?
2. How successful are the existing State telehealth/telemedicine projects and networks and do they interact with one another or operate independently?
3. What are the perceived benefits or impediments to establishment of a Statewide telehealth/telemedicine network?
4. What are you as a health care provider/institution facilitating/providing to implement telehealth/telemedicine in your area?
5. What do you as a health care provider/institution require from the State to assist you to expand your current telehealth/telemedicine project/network?

These questions prompted lively discussion and dialogue, with recommendations included later in this report. In addition, and most notably, Senator Hannon and Assemblywoman Gunther spoke about what is perhaps the greatest barrier to New York State moving forward with innovative healthcare technology for all State residents – the lack of a cohesive approach and focused

dialogue. Senator Hannon specifically addressed the issue that telemedicine is only one small subset of health technological services that could be available statewide. Telemedicine encompasses a number of challenges that cannot be addressed, though, without first developing a basic statewide foundation of health technology, and access to it, as well as standardized language and conversation in which all New York State healthcare stakeholders, including the patient, can engage.

While some of the participants spoke about the availability of health technology services in specific regions of New York State, it was clear that much of the resources, funding and focus was centered on further developing those areas as distant or "hub" sites (locations that are traditionally already rich in access to healthcare resources, i.e., urban centers) and not so much to developing the basic, yet necessary, foundation of such services for the complementary originating or "spoke" sites (traditionally rural areas with little to no healthcare access). Simply stated, the majority of money to develop health technology in New York State has been invested in large-capacity health care centers (medical research facilities, university research centers, etc.) in the State's urban and metropolitan areas. While some suburban areas may have the capacity to tap in to neighboring health technology systems, the vast majority of the State's rural areas have been responsible for developing their own systems and models that, while successful, have not received the proper funding to help build them into a cohesive Statewide health technology network.

New York State's health technology landscape is a patchwork system that is riddled with medical coverage gaps, and overlapping services. Essentially, instead of promoting and building a statewide network made up of unique expertise in which a diverse range of assets and needs are represented, the gap between the easy healthcare access metro areas and low to no healthcare rural regions has been further widened. A cohesive approach to developing an organized system that meets the region-specific needs of the State's diverse populations would result in significant cost savings demonstrated in the evidence-based research available on the topic. A shift from a focus on regional systems and their isolated cost-savings to development of a basic health technology infrastructure in low healthcare access areas of the state is needed in order to move forward in building a robust health technology infrastructure in New York State.

Definitions of Telehealth and Telemedicine

Telehealth – the U.S. Centers for Medicare and Medicaid Services define telehealth as: the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and

information across distance. Telehealth includes such technologies as telephones, facsimile machines, electronic mail systems, and remote patient monitoring devices, which are used to collect and transmit patient data for monitoring and interpretation. While they do not meet the Medicaid definition of telemedicine they are often considered under the broad umbrella of telehealth services. Even though such technologies are not considered "telemedicine," they may nevertheless be covered and reimbursed as part of a Medicaid coverable service, such as laboratory service, x-ray service or physician services (under Section 1905(a) of the Social Security Act)

Telemedicine – the U.S. Centers for Medicare and Medicaid Services define telemedicine, for purposes of Medicaid, as a system to improve a patient's health by permitting two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site. This electronic communication means the use of interactive telecommunications equipment that includes, at a minimum, audio and video equipment. Telemedicine is viewed as a cost-effective alternative to the more traditional face-to-face way of providing medical care (e.g., face-to-face consultations or examinations between provider and patient) that states can choose to cover under Medicaid.

Recent Medicaid Redesign Team (MRT) Efforts

In early 2011, the Department of Health made some enhancements to telehealth, based on Proposal #153 of the Medicaid Redesign Team that reduces regulatory barriers and provides payment incentives.

Specifically, the MRT adopted a proposal calling for the State to develop innovative telemedicine applications by reducing regulatory barriers and providing monetary incentives, with the goal of promoting and enhancing telemedicine coverage, thereby increasing access to both primary and specialty health care services.

Twelve states currently mandate health insurers to cover and reimburse services provided through telemedicine:

- Virginia
- California
- Colorado
- Georgia
- Hawaii
- Kentucky
- Louisiana
- Maine
- New Hampshire
- Oklahoma
- Oregon
- Texas

In New York State, telehealth/telemedicine services are great resources for rural areas where there is limited access to doctors. Assemblywoman Aileen Gunther, also a nurse, stated that telehealth/telemedicine is cost-effective and cutting edge, with data on its success having been collected for years.

Existing Statewide Programs and Successes

Proven statewide telehealth partnerships exist across the United States, including these proven entities operating across New York State:

Western New York Rural Broadband Health Network (WNYRBHN)

Western New York AHEC

Ken Oakley

Initiated in 2007 by the Western New York Area Health Education Center through a series of Federal Communications Commission grants, the Western New York Rural Broadband Health Network is a 45-partner integrated network that reaches out to 20 western New York counties by connecting multiple health care providers using a myriad of telehealth applications.

WNY RBHN offers a point of connection between direct health care service providers, health professions, schools and the communities they seek to serve. Broadband is an essential element in these successes, whose applications include, but are not limited to telemedicine consults, video conferencing, MOVI – desktop video conferencing and streaming/taping.

The WNYRBHN network provides a secure, dedicated healthcare “backbone,” accessible to all WNYRBHN partners, with successful results in providing such services as stroke care, remote UICU monitoring, pediatric and geriatric primary care, pediatric dental screening and psychiatric consults.

As Western New York Area Health Education Center (AHEC) CEO, Dr. Kenneth Oakley also spoke of his personal experiences with teleconsultations in relation to his grandson who has suffered with many health issues. After years of frustrating and largely unsuccessful diagnoses and treatments, teleconsultations with Columbia Hospital ultimately led to his grandson’s correct diagnosis and improved treatment. Clearly, Dr. Oakley is an advocate of telehealth not just as a health care administrator, but also as one with a personal experience.

*Fort Drum Regional Health Planning Organization (FDRHPO)
North Country Telemedicine Project*

The North Country Telemedicine Project is a regional fiber optic telecommunications/telemedicine network that connects participating health care entities including urban and rural hospitals, primary care, mental health and specialty clinics, public health departments and the U.S. Fort Drum Medical Activity (MEDDAC). These providers are located at sites operating in Jefferson, Lewis and St. Lawrence Counties in northern New York, as well as in four urban facilities located in Syracuse and Utica, providing consultative and specialty care. Currently this network provides access for 160,000 residents of the Fort Drum region.

*Finger Lakes Community Migrant Health
Mary Ann Zelazny*

Focusing mostly on migrant workers who do not have the resources to access health care, Ms. Zelazny reported that patients in her area are limited to telehealth options. Dental health for migrant children is huge – 40% have advanced tooth decay – and Finger Lakes uses telehealth with Eastman Dental to treat these children. The program has been a resounding success. Their revenue stream comes from Federally Qualified Health Centers (FQHCs) and some can be billed to Medicaid. Finger Lakes FQHCs' use of telehealth for children's dental needs also decreases the need for specialists. Children who need oral surgery also use telehealth/telemedicine to decrease the number of visits parents would have otherwise needed to schedule with the oral surgeon. Finger Lakes provided an example of a procedure that required 4 visits. With telehealth, three of those visits were completed using video conferencing. The fourth visit was the actual surgery. Additionally, the normal eight month wait time for surgery was cut down to four months with the utilization of telehealth.

In addition, Ms. Zelazny reported that her organization conducts telehealth conferences with a counselor in the room for the first 15 minutes with a mental health patient. Often, it is a struggle to get people to go to mental health clinics because of the stigma surrounding such. With the use of telehealth, these individuals do not have to leave the primary care setting to get additional help. It is a good learning experience for onsite health care providers, and Ms. Zelazny reported that it keeps people healthier.

*Rochester General Health
Cynthia Gordon*

Cynthia Gordon, Director of Telehealth Services for Rochester General Health, joined the roundtable via teleconference. She reported that telehealth gives patients access to additional specialists at local health care facilities that might not otherwise be available, and that this has been a great success. Ms. Gordon added that telemedicine allows a practitioner to do day-to-day monitoring of a patient remotely, even making it possible to hear heart and lung sounds. This technology is widely accepted by the patients.

Ms. Gordon also stressed that telehealth is being driven by the health workforce shortage, which is especially acute in rural areas. Computer monitoring of patients is saving the costly practice of sending out nurses to remote locations. In addition, hospitalization rates have been reduced from 30% to 16% since the monitoring program has been in place. She said solutions revolve around eliminating barriers between counties, and that regional telehealth programs would help in place of a myriad of different county programs. To address concerns about overuse raised by Blue Cross and Blue Shield, Ms. Gordon suggested making certain to use experienced practitioners, monitoring usage and making certain consumers are on board.

*At Home Care, Inc.
Laurie Neander*

Ms. Neander reports that incorporating remote patient monitoring systems into integrated disease management pathways as demonstrated is cost efficient and results in positive patient outcomes. At Home Care, Inc. has demonstrated improved efficiencies in delivering care, while decreasing costs, as:

- RN visit time is reduced;
- travel and mileage costs for monitoring patients remotely are only incurred at the time of device installation in the home, saving travel time and cost associated with frequent face to face visits;
- for RNs working in rural regions, the average capacity of a full-time RN is direct visits with 4.5 patients in their homes per day. Utilizing telehealth technology, a single RN may remotely visit approximately 75 patients per day.

Victoria Hines, CEO of Visiting Nurse Services of Monroe County

In regard to patient engagement, Ms. Hines' organization has non-video biometric monitoring which they have had "terrific results" using. They attribute those good results to patient engagement.

Other successes:

- Telehealth/telemedicine results in decreased hospital stays, facilitates translation/language barriers and makes more counselors available for mental health services (Zelazny)
- Rural hospitals which may have no intensive care doctors can use telehealth in place of ICU (Gordon)
- Telehealth/telemedicine has helped with workforce shortages, increased medication compliance and increased compliance for diabetic patients – which resulted in better disease management (Dubeck/Oakley)
- Telemedicine studies are small, but results show that telemedicine saves money, particularly in ER visits, some showing a 22% reduction in ER visits (Oakley)
- Telehealth allows a greater percentage of Visiting Nurse patients to stay at home, suggesting that mandatory or required telehealth as a standard part of Long Term Care treatment be included (Mazzacco)

Problems/Barriers

Senator Young, in acknowledging the success of many individual programs across New York State, also sought discussion related to barriers faced by providers and organizations in implementing a statewide telehealth/telemedicine network. While several entities mentioned the need for increased funding for telehealth and telemedicine, it was acknowledged and largely agreed that lack of access or gaps in broadband coverage, particularly in rural areas of the State, was detrimental to implementation efforts.

In addition, the following barriers were identified as the most difficult to address:

- no systematic funding or reimbursement for claims
- credentialing
- paying for non-physician (RN) time

- o identifying the correct provider to receive information
- o identifying and authenticating the patient
- o federal requirements for originating sites are too narrow

Specifically, panelists highlighted the following areas as the greatest barriers to implementation of telehealth/telemedicine:

Credentialing

Healthcare Association of New York State/New York State Department of Health

The credentialing issue consists of two separate and distinct obligations that are impeding telemedicine providers. First, hospitals are required by the NYS Public Health Law (Section 2805) to credential practitioners before granting them privileges to treat patients. The required credentialing involves verification of training, experience and licensure. The second is assessment of practitioner performance, known as "peer review." Peer review refers to an assessment of a practitioner's performance by his or her peers, normally meaning by physicians who practice in the same or similar areas of specialty. Peer review is normally conducted as a part of the hospital's overall quality assurance program, which is also required by the same section of law.

DOH has determined, consistent with Center for Medicaid Services requirements, that the credentials verification portion of the credentialing process for telemedicine purposes can be fulfilled by the hospital where the physician providing the telemedicine consult resides. This part of credentialing is basically a documentation review that verifies medical school graduation, residency training in the area of specialty in which the physician practices and that the physician is currently licensed in New York State. However, the hospital receiving the consult via telemedicine (which is required to credential the physician in order to grant them the privilege of providing consultations) is still obligated to conduct a peer review/performance assessment of that physician's practice in recommending treatment of patients at the originating site to ensure the services provided are of high quality.

The problem that arises is the likelihood that there are no peers on the medical staff, which is why the telemedicine consult was needed in the first place – to access the services of a specialist who is not on staff at the hospital. That leaves the hospital where the consult was received having to either do the best they can in reviewing the physician’s work or to seek expert assistance elsewhere, generally through a contractual relationship that burdens the originating site with additional expenses. This phenomenon creates a barrier to the expansion of telemedicine. One alternative might be for the distant site hospital where the physician providing the telemedicine consult resides to be able to fulfill the peer review responsibility of the originating site hospital where the consultation is received, by virtue of the peer review already being conducted at the distant site. There are likely other approaches that would also work to ensure high quality telemedicine.

Reimbursement

Denise Young, Fort Drum Regional Health Planning Organization

Alexis Silver, Home Care Association of NYS

Ms. Young reported that Fort Drum has a rural health pilot program and that their biggest challenge, in addition to finding available specialists in rural New York, is reimbursement across the board. For example, Medicaid only covers telepsychiatry, unless it is provided to a patient by a provider in limited settings. Another barrier according to Ms. Young is “credentialing.” Health care providers must be credentialed at both ends – at the provider location and at the patient location.

The Home Care Association raised the reimbursement issue as well. According to the Home Care Association’s Alexis Silver, Section 3614 of the Public Health Law establishes telehealth as a distinct service provided and reimbursed through New York’s Certified Home Health Agencies (CHHAs) and Long Term Home Health Care Programs (LTHHCPs). The development of this approach in the 2007 Legislative Session was essential to ensuring the development, integration and operational viability of telehealth services in the State. Because the Medicaid payment mechanisms for home care are currently being transitioned by the State Health Department to episodic and contractual-managed care payment structures, these payment policies must also clearly articulate and ensure the maintenance of the current, distinct telehealth payment method and operating program through CHHAs and LTHHCPs. According to HCA, the CHHA/LTHHCP home telehealth payment and program operation should continue regardless of whether the patient’s care is otherwise being reimbursed under an episodic, managed care or residual fee-for-service payment arrangement. In the case of episodic or managed care, the distinct payment should be a parallel payment to the CHHA/LTHHCP for the telehealth component.

Lack of Providers

Dr. Stewart Gabel, NYS Office of Mental Health

Dr. Gabel stressed that New York State has among the largest number of child and adolescent psychiatrists (CAPs) of any state, but that there is a significant disparity in distribution, with rural and underserved areas particularly hard hit. In fact, 24 New York counties (approximately 40%) have no child psychiatrists, and it is a major challenge to serve these areas. Dr. Gabel also spoke to the fact that approximately 15-20% of youth have mental health disorders, but that only about 25-30% of this population receives mental health treatment. Early intervention is key in many cases.

Dr. Gabel suggests that the shortage of CAPs and more immediate treatment of child patients can be accomplished by 1) treating children through telemedicine, 2) consultations with community mental health centers and 3) Project Teach, a community consultation, education and liaison program for primary care providers.

Project Teach utilizes mobile units to bring telemedicine to unserved areas, as many children who need mental health treatment are going only to their primary care doctor. Project Teach and other programs are paid for through OMH funds. OMH contracts with Columbia University, New York University, Four Winds and other mental health centers.

Dr. Gabel also reiterated the need for adequate reimbursement.

Barriers to Access

Alexis Silver, Home Care Association of NYS

It is well known that some geographic areas lack telehealth services and that CHHAs' or LTHHCPS' physical on-site service area inhibits the ability of existing providers to extend service to regions lacking access, including the absence of existing telehealth service providers in these areas. As the modality and capacity of telehealth is inherently designed and intended for remote, technological monitoring, CHHAs' or LTHHCPS' "telehealth region" should be allowed to expand beyond the geographic boundaries of its traditional on-site service area, into areas where access can be provided or better supported. This represents not only a viable path for access, but cost-effectiveness. DOH has recently requested applications for the establishment of new CHHAs or expansion of existing CHHAs.

Patient Identification

Rachel Block, Department of Health, Office of Technology

The Department of Health recognizes that telemedicine is a key component of current and future health IT and care coordination models. Governance, policy and technical infrastructure to support health information exchange, including telemedicine applications and tools, is necessary in order to implement a successful statewide program. In this vein, DOH is working through its Health Care Efficiency and Affordability (HEAL) grant program to:

- advance New York's health information infrastructure based on clinical and programmatic priorities and specific goals for improving quality, affordability and outcomes;
- align health information infrastructure as an underpinning to improved coordination of patient care leveraging new care delivery and reimbursement models – the Patient Centered Medical Home (PCMH);
- build on health information infrastructure and advance key health reforms included in the PCMH model to improve care; and
- advance health IT as a key component to payment and broad health care reform

Additionally, other issues to be addressed include:

- the need for technical implementation and adoption of support services
- integration of data into electronic health records (EHRs)
- addressing of payment policy and care coordination models

and:

- appropriate identification of the patient/verification that the patient is who the provider thinks they are
- identifying the correct provider
- protecting the identity of the provider and the consumer.

EMT Transport/Telestroke

Fred Heigel, Healthcare Association of New York State

In 2007, DOH initiated a Telestroke program modeled after a similar successful program in Georgia. In New York's Telestroke program, rural hospital emergency departments (known as "spokes") are connected via telemedicine equipment with a medical center that has full time neurologist coverage (known as the "hub"). Emergency treatment of stroke patients is determined by rapidly completed patient evaluations and in consultation with a neurologist.

Emergency medical services personnel are trained to recognize the signs of a stroke, and their actions are protocol driven – EMS protocol for patients displaying stroke symptoms is to transport them to the nearest designated stroke center. That may and does involve bypassing hospitals that are not designated stroke centers. Most rural hospitals, including those participating in the Telestroke program, are not designated stroke centers.

There are both neurologist coverage and patient evaluation/workup requirements for obtaining stroke center designation. The Telestroke program is accepted by DOH as meeting the neurologist coverage requirement. However, there are also requirements involving the rapid evaluation of suspect stroke patients that are time sensitive and cannot be met at all hours of the day by most rural hospitals. Thus, ambulances transport patients assessed as experiencing a stroke past hospitals that do not have stroke center designation to take them to hospitals possessing the designation. That limits rural hospitals participating in the Telestroke program to using that program to the benefit of suspect stroke patients arriving by methods other than by ambulance.

Additional observations:

- File-rider, fee-for-services vs. Medicaid home
- "Spokes" cannot do quality review
- Telemedicine from out-of-state could be problematic
- Need to change geographic boundaries and create regional telehealth programs
- For the purposes of payment for covered treatment or services provided through telehealth, removing the limit imposed upon the type of setting where services are provided for the patient or by the health care provider
- Need for transportation managers for Medicaid reimbursement purposes.

RECOMMENDATIONS

Based on the roundtable discussion, the Commission, along with the sponsoring Committees, is considering the following recommendations for review and action.

1. Establishment of a Statewide Telehealth/Telemedicine Network

The most comprehensive and far-reaching goal, as evidenced by participant discussion in the roundtable dialogue, is the promotion, development, provision and accessibility of telehealth/telemedicine services across New York State. Coordinating and focusing State telehealth/telemedicine policy and program planning will serve as a catalyst to expand and improve such programs in communities across the State, through adoption of a statewide policy to direct such health services. Through an integrated telecommunications system, patients and providers across the continuum of care would have increased access to medical treatment and state-of-the-art health care, as well as educational and professional training opportunities.

2. Credentialing

There is a need to address, legislatively, the fact that the credentialing process for telemedicine creates a barrier to the expansion of telemedicine. The problem that arises, particularly in rural hospitals, is the likelihood that there are no peers on the medical staff, which is why the telemedicine consult was needed in the first place – to access the services of a specialist who is not on staff of the hospital. The hospital where a consult is received must either do their best in reviewing the physician's work or seek expert assistance elsewhere generally through a contractual relationship that bears expense. This is in light of the fact that DOH has determined, consistent with Center for Medicaid Services requirements, that the credentials verification portion of the credentialing process for telemedicine purposes can be fulfilled by the hospital where the physician providing the telemedicine consult resides.

3. Consumer Education and Awareness

Participants stressed the importance of keeping people, especially the elderly, in their homes longer and educating the senior population through the use

of kiosks in senior housing centers, for example, in order to keep them out of hospitals and other health centers. There is some funding for this through the Department of Health HEAL grant program. Also helpful would be providing health information in areas where seniors congregate, particularly in rural areas, and stressing the importance of telehealth as a good prevention tool. (Lutheran Social Services)

4. Creation of Telehealth Resource Centers

These Centers would serve the entire state – particularly rural areas. Rochester General has found that, as they move into smaller health care facilities, these areas have little idea how to build a telehealth center and little access to resources to help them build a telehealth spoke site. In addition, a common need and often repeated request is for help in planning a telehealth program and in identifying equipment needs and appropriate technologies. There is an imperative need to provide technical assistance to health care organizations, networks and providers within New York State and in developing a telehealth resource center plan. The western part of New York State is an excellent pilot which could then be replicated throughout the entire state (WNY AHEC as a model).

5. Addressing Payor Funding

One recommendation is that increased payor funding, both private and federal, will allow for more providers to participate in telehealth consults, resulting in increased accessibility and availability of specialists. In addition, originating site requirements under the Medicaid program should be broadened to permit telemedicine consults to take place in individual providers' offices. (Rochester General)

Another recommendation is that telehealth be mandated for reimbursement from payors as a stand-alone service. Any practitioner who would otherwise be entitled to receive payment for in-person services delivered in the home should be entitled to be paid for such services if they are provided using appropriate remote monitoring technology. Reimbursement for such services should be subject to the same guidelines stated within the physicians' fee schedule. Such services should be allowed, provided that the service meets required documentation criteria for an in-person visit and does not substitute for needed in-person care or in-person home services. (Advantage Home Telehealth)

2012 ENACTED STATE BUDGET

As part of the 2012 State Budget which was signed into law on March 30, 2012, the Commission on Rural Resources was successful in securing a \$50,000 allocation for the purposes of establishing a rural home telehealth delivery demonstration program, to be set up in Chautauqua County.

The purpose of the demonstration program is to study patients receiving telehealth services who have been diagnosed with congestive heart failure, diabetes and/or chronic pulmonary obstructive disease and whose medical, functional and/or environmental needs are appropriately met at home through the application of telehealth services.

The home health organization responsible for coordinating the study will report on the cost of providing telehealth services, the quality of care provided through telehealth services and the outcomes of patients receiving such services. An evaluation of the study will be required in relation to the provision of telehealth services for each condition, so as to provide cost benchmarks with and without telehealth care, and to provide cost benefit measurements in terms of the quality benefit outcomes for each of the conditions addressed via telehealth.

APPENDICES

APPENDIX A

Statistics

Healthcare costs in the United States continue to rise and are straining available resources. National statistics reveal the following, for example:

- In 2009, health care costs were expected to reach 18% of U.S. Gross Domestic Product (GDP). (Council of Economic Advisors, Executive Office, Federal)
- According to the White House Council of Economic Advisors, real per person spending on health care has risen by 40% in the past decade.
- According to the US Dept of Health and Human Services, 1/5 of Americans currently live in locations with inadequate access to primary care physicians.
- By 2006, 46% of community hospitals reported moderate or high use of HIT (Health Information Technology), compared to 37 percent in 2005. (American Hospital Association)

APPENDIX B

National Telehealth Models

California Telemedicine and eHealth Center (CTEC)

California's Telehealth Advancement Act of 2011 opened the door for far-reaching expansion of telehealth services in the state of California. The law was written as an update to California's 1996 Telemedicine Development Act, and allows for: a broader range of telehealth services; the expansion of telehealth providers to include all licensed healthcare professionals; the expansion of telehealth care settings; and the ability for California hospitals to establish medical credentials for telehealth providers more easily.

Georgia Partnership for TeleHealth (GPT)

Georgia Partnership for TeleHealth has become one of the most robust, comprehensive networks in the nation and includes nursing homes, school clinics, jails, clinics, ERs, trauma, stroke, primary care, child advocacy and continuing education. Georgia law mandates all payers to cover telemedicine, and the network has more than 350 partners and locations. While GPT had a mere eight encounters in January 2006, they had more than 25,000 encounters in 2010. That number is expected to have doubled in 2011. There are more than 175 specialists and health care providers, representing over 40 specialties, participating within the GPT network. Providing access to healthcare via telemedicine has proven to cut costs on travel and work time and provides earlier access to care, thus preventing increased costs due to untreated health conditions.

APPENDIX C

TELEMEDICINE CREDENTIALING BILL LANGUAGE

AN ACT to amend the public health law, in relation to the granting of hospital privileges, to providers of telemedicine services

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. The public health law is amended by adding a new section 2805-u to read as follows:

§ 2805-u. Credentialing and Privileging of Health Care Practitioners Providing Telemedicine Services. 1.

Definitions: For purposes of this section:

(a) "Distant site hospital" means a hospital licensed pursuant to this article, or a hospital licensed by another state, that has entered into an agreement with an originating hospital to make available one or more health care practitioners that are members of its clinical staff to the originating hospital for the purposes of providing telemedicine services. To qualify as a distant site hospital for purposes of this article, a hospital licensed by another state must comply with the federal regulations governing participation by hospitals in Medicare.

(b) "Health care practitioner" shall mean a health care provider as defined in section two hundred thirty-eight of this chapter.

(c) "Originating hospital" means the hospital at which a patient is located at the time telemedicine services are provided to him or her.

(d) "Telemedicine" means the delivery of clinical health care services by means of real time two-way electronic audio-visual communications which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient's health care while such patient is at the originating site and the health care provider is at a distant site.

2. When telemedicine services are provided to an originating hospital's patients pursuant to an agreement with a distant site hospital, the originating hospital may, in lieu of satisfying the requirements set forth in section 2805-k of this article, rely on the credentialing and privileging decisions made by the distant site hospital in granting or renewing privileges to a health care practitioner who is a member of the clinical staff of the distant site hospital, provided that:

(a) the distant site hospital participates in Medicare and Medicaid;

(b) each health care practitioner providing telemedicine is licensed to practice in New York State;

(c) the distant site hospital, in accordance with requirements otherwise applicable to that hospital, collects and evaluates all credentialing information concerning each health care practitioner providing telemedicine services and performs all required verification activities, and acts on behalf of the originating site hospital for such credentialing purposes;

(d) the distant site hospital reviews periodically, at least every two years, and as otherwise warranted based on outcomes, complaints or other circumstances, the credentials, privileges, physical and mental capacity, and competence in delivering health care services of each health care practitioner providing telemedicine services, consistent with requirements otherwise applicable to that hospital; reports the results of such review to the originating hospital; and notifies the originating hospital immediately upon any suspension, revocation, or limitation of such privileges.

(e) With respect to each distant-site health care practitioner, who holds privileges at the originating hospital, the originating hospital shall conduct a periodic internal review, at least every two years, of the distant-site practitioner's performance of these privileges and shall send the distant-site hospital such performance information for use in the distant hospital's periodic appraisal of the distant-site physician or practitioner. Such information shall include, at a minimum, all adverse events that result from the telemedicine services provided by the distant-site health care practitioner to the originating hospital's patients, all complaints the originating hospital has received about the distant-site practitioner, and any revocation, suspension or limitation of the distant-site practitioner's privileges by the originating hospital.

(f) The agreement entered into between an originating site hospital and distant site hospital shall be in writing and shall, at a minimum:

(i) provide the categories of health care practitioners that are eligible candidates for appointment to the originating hospital's clinical staff;

(ii) require the governing body of the distant site hospital to comply with the Medicare conditions of participation governing the appointment of medical staff with regard to the health care practitioners providing telemedicine services;

(iii) itemize the credentialing information to be collected and the required verification activities to be performed by the distant site hospital and relied upon by the originating hospital in considering the recommendations of the distant site hospital;

(iv) require each distant site health care practitioner providing telemedicine services to be licensed to practice in New York State and privileged at the distant-site hospital;

(v) require the distant site hospital to provide to the originating hospital a current list of each distant-site health care practitioner's privileges at the distant-site hospital,

(vi) require the distant site hospital to conduct a periodic review consistent with requirements otherwise applicable to that hospital, at least every two years, and as otherwise warranted based on outcomes, complaints or other circumstances, the credentials, privileges, physical and mental capacity, and competence in delivering health care services of each health care practitioner providing telemedicine services; to provide the originating hospital with the results of such review; and to notify the originating hospital immediately upon any suspension, revocation, or limitation of such privileges.

3. Nothing contained in this section shall be construed as allowing an originating hospital to delegate its authority over and responsibility for decisions concerning credentialing and granting staff membership or professional privileges to health care practitioners providing telemedicine services.

4. Notwithstanding any contrary provision of law, an originating hospital shall not be required to provide a physical examination or to maintain recorded medical history including immunizations for a health care provider providing consultations solely through telemedicine from a distant site hospital.

§ 2. This act shall take effect immediately.

APPENDIX D

TELEMEDICINE CREDENTIALING BILL MEMO

SENATE BILL NUMBER:

ASSEMBLY BILL NUMBER:

SENATE SPONSOR(S): YOUNG

ASSEMBLY SPONSOR(S): Gunther

INTRODUCED AT THE REQUEST OF: NYS Legislative Commission on Rural Resources

TITLE OF BILL:

An act to amend the public health law, in relation to telemedicine credentialing.

PURPOSE:

To provide for the credentialing of health care providers providing telemedicine services

SUMMARY OF PROVISIONS:

Section 1 amends section 2805-u of the public health law to permit a hospital where a patient is receiving telemedicine services to enter into an agreement with a distant site hospital for credentialing, privileging and peer review of a distant site healthcare practitioner. The distant site hospital must be licensed and if from another state, must comply with federal Medicare regulations.

The agreement requires the distant site hospital where a consulting physician is located to collect information and perform all required verification, quality assurance and peer review activities imposed upon the originating site hospital. The agreement must, at a minimum, provide that the originating site hospital is ultimately responsible for physician credentialing. The agreement must also enumerate: the categories of healthcare providers eligible for appointment to the distant site hospital medical staff; the credentialing information collected and verification activities performed by the distant site hospital; the members of the originating site hospital staff considering the staffing recommendations of the distant site staff; that the distant site provider is credentialed at the distant site hospital; and the privileges held by the distant site provider at the distant site hospital.

The originating hospital is required to report all adverse events resulting from a distant site health care provider's telemedicine services to the distant site hospital.

JUSTIFICATION:

Hospitals are required by the New York State Public Health Law to credential practitioners before granting them privileges to treat patients. The required credentialing involves verification of training, experience and licensure as well as performance. The assessment of practitioner performance is known as "peer review." Peer review refers to an assessment of a practitioner's performance by his or her peers, normally meaning by physicians who practice in the same or similar areas

of specialty. Peer review is normally conducted as a part of the hospital's overall quality assurance program.

The New York State Department of Health has determined, consistent with CMS requirements, that the credentials verification portion of the credentialing process for telemedicine purposes can be fulfilled by the hospital where the physician providing the telemedicine consult resides. This part of credentialing is basically a documentation review that verifies medical school graduation, residency training in the area of specialty in which the physician practices and that the physician is currently licensed in New York State.

However, the hospital receiving the consult via telemedicine (which is required to credential the physician in order to grant them the privilege of providing consultations) has an obligation to conduct a peer review/performance assessment of that physician's practice in recommending treatment of patients at the patient-site hospital to ensure the services provided are of high quality. Unfortunately, in situations where telemedicine is used, there are often no peers on the medical staff at the patient-site hospital, thus requiring a telemedicine consult with a distant-site hospital to access the services of a specialist.

This requirement forces the patient site hospital to either rely on the limited information they have at the patient site hospital or to seek expert assistance elsewhere, with an additional cost to the patient hospital. This phenomenon creates a barrier to the expansion of telemedicine.

This legislation would remove that barrier by allowing the patient-site hospital to rely upon the distant site hospital where the physician who provides the telemedicine consult resides to be able to fulfill the peer review responsibility of the hospital where the consultation is received by virtue of the peer review already being conducted at the site providing the consultation.

LEGISLATIVE HISTORY:

New Bill.

FISCAL IMPLICATIONS:

None.

EFFECTIVE DATE:

Effective immediately.

APPENDIX E

TELEHEALTH PARITY ACT BILL LANGUAGE

Section 1. Subdivision 1 of section 2 of the public health law is amended by adding five new paragraphs (o), (p), (q), (r) and (s) to read as follows:

(o) Distant site. The term “distant site” means a site at which a health care provider is located while providing health care services by means of a telecommunications system.

(p) Health care provider. The term “health care provider” means a health care provider as defined in section two hundred thirty-eight of this chapter.

(g) Originating site. The term “originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of a telecommunications system.

(r) Telehealth. The term “telehealth” means the mode of delivering health care services by means of information and communications technologies including, but not limited to, telephones, facsimile machines, electronic mail systems, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient’s health care while such patient is at the originating site and the health care provider is at a distant site. Such term shall include telemedicine.

(s) Telemedicine. The term “telemedicine” means the delivery of clinical health care services by means of real time two-way electronic audio visual communications which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient’s health care while such patient is at the originating site and the health care provider is at a distant site.

§ 2. Subdivision 3-c of section 3614 of the public health law is amended by adding a new paragraph (e) to read as follows:

(e) Notwithstanding the provisions of subparagraph (i) of paragraph (b) of subdivision seven of section forty-four hundred three-f of this chapter or section three hundred sixty-four-i of the social services law, telehealth services and reimbursement for such services provided to certified home health agencies, long term home health care programs and AIDS home care programs, and licensed home care services agencies under subcontract with such agencies or programs, shall continue to be provided pursuant to this subdivision.

§ 3. Subsection (i) of section 3216 of the insurance law is amended by adding a new paragraph 29 to read as follows:

(29) Every policy delivered or issued for delivery in this state which provides coverage for hospital, medical or surgical care shall include coverage for telemedicine services, as defined in section two of the public health law, provided that such services meet the requirements of federal law, rules and regulations for medical assistance for needy persons provided pursuant to title eleven of article five of the social services law, and for telehealth services that are, at a minimum, those required to be provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

§ 4. Subsection (k) of section 3221 of the insurance law is amended by adding a new paragraph 18 to read as follows:

(18) Every group or blanket policy delivered or issued for delivery in this state which provides coverage for hospital, medical or surgical care shall include coverage for telemedicine services, as defined in section two of the public health law, provided that such services meet the requirements of federal law, rules and regulations for medical assistance for needy persons provided pursuant to title eleven of article five of the social services law, and for telehealth services that are, at a minimum, those required to be provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

§ 5. Paragraph 2 of subsection (a) of section 3229 of the insurance law, as amended by chapter 659 of the laws of 1997, is amended to read as follows:

(2) a home care benefit with personal care, nursing care, adult day health care [and], respite care services, telemedicine services, as defined in section two of the public health law, provided that such

telemedicine services meet the requirements of federal law, rules and regulations for medical assistance for needy persons provided pursuant to title eleven of article five of the social services law, and telehealth services that are, at a minimum, those required to be provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law, which shall provide total benefits in an amount determined by regulations of the superintendent;

§ 6. Section 4303 of the insurance law is amended by adding a new subsection (ii) to read as follows:

(ii) Every contract issued by a medical expense indemnity corporation, a hospital service corporation or a health service corporation which provides coverage for hospital, medical or surgical care shall include coverage for telemedicine services, as defined in section two of the public health law, provided that such services meet the requirements of federal law, rules and regulations for medical assistance for needy persons provided pursuant to title eleven of article five of the social services law, and for telehealth services that are, at a minimum, those required to be provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

§ 7. The opening paragraph of section 367-u of the social services law is designated subdivision 1 and a new subdivision 2 is added to read as follows:

2. Subject to the approval of the director of the budget, the commissioner shall not exclude from the payment of medical assistance funds the provision of medical care through telemedicine services, as defined in section two of the public health law, provided that such services meet the requirements of federal law, rules and regulations for the provision of medical assistance pursuant to this title, and for telehealth services that are, at a minimum, those required to be provided pursuant to subdivision three-c of section thirty-six hundred fourteen of the public health law.

§ 8. This act shall take effect immediately.

APPENDIX F

TELEHEALTH PARITY ACT BILL MEMO

SENATE BILL NUMBER:

ASSEMBLY BILL NUMBER:

SENATE SPONSOR(S): YOUNG

ASSEMBLY SPONSOR(S): Gunther

INTRODUCED AT THE REQUEST OF: NYS Legislative Commission on Rural Resources

TITLE OF BILL:

An act to amend the insurance law and the social services law, in relation to the provision of telehealth services.

PURPOSE:

Requires insurers and medical assistance for needy persons to provide coverage for the provision of telehealth services.

SUMMARY OF PROVISIONS:

Section one would amend subdivision 1 of section 2 of the public health law to provide definitions for "distant site," "health care provider," "originating site," "telehealth" and "telemedicine."

Section five would ensure continued telehealth services and reimbursement when provided by certified home health agencies, long term home health care programs and AIDS home care programs, and licensed home care services agencies under subcontract with such agencies or programs, under the managed long term care program.

Section two amends subdivision 3-c of section 3614 of the public health law by adding a new paragraph (e) to provide continued reimbursement for home telehealth services provided by certified home health agencies, long term home health care programs and AIDS home care programs, and licensed home care services agencies in the transition to episodic payment, managed long term care and mainstream managed care.

Sections three, four, five and six would amend various provisions of the insurance law to require individual accident and health insurance, group or blanket accident and health insurance, medical expense indemnity corporations or hospital service corporations that provide hospital, medical or surgical care to also provide coverage for telemedicine services, provided the services meet federal Medicaid requirements, and telemedicine services to the same extent as the home telehealth program provided under paragraph 3-c of subdivision 3614 of the public health law.

Section seven would amend the social services law to prohibit the exclusion of telehealth services from reimbursement under Medicaid solely because the otherwise covered service was delivered by telehealth.

Section eight states the enactment date.

JUSTIFICATION:

Telehealth, including telemedicine, can benefit patients, especially rural patients hampered by economic or geographic restrictions, in many ways. Due to significant quality and fiscal improvements, patients see fewer hospitalizations and costly visits to emergency rooms; expanded access to providers; faster, more convenient and timely treatment; better continuity of care; better coordination of care; reduction of lost work time and travel costs; and the ability to remain with support networks and age in place at home.

Persons of all ages who suffer from chronic diseases will have the opportunity to stay in their homes longer, abnormal events may be detected before they turn into a hospital visit, vital signs can be monitored remotely by registered nurses, patients can get help with medication adherence and be encouraged to take ownership of their own well-being by better understanding the correlation between their choices and their health outcomes.

Patients can receive consultations at a provider's office, not just from that provider, but from doctors, nurse practitioners, physicians' assistants, dentists across the state and world.

However, to ensure that the field of telehealth and telemedicine can reach its full potential, these services must be reimbursed in the same manner as those provided face to face. Any individual who would otherwise be entitled to receive coverage for in-person encounter-based monitoring or consulting services should be entitled to receive such services through the use of remote monitoring or remote consults using real-time audio-visual telecommunications.

Enabling health care professionals to make use of available technology will empower them to better serve their patients and enhance health patient outcomes.

LEGISLATIVE HISTORY:

New Bill.

FISCAL IMPLICATIONS:

Undetermined.

EFFECTIVE DATE:

Effective immediately.

APPENDIX G

NEW YORK STATE TELEHEALTH/TELEMEDICINE DEVELOPMENT ACT BILL LANGUAGE (S. 662/A. 3793)

AN ACT to amend the public health law, in relation to promoting the development, provision and accessibility of telehealth/telemedicine services in New York state; and to amend the state finance law, in relation to establishing a New York state telehealth/telemedicine development and research grant fund

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. This act shall be known and may be cited as the "New York state telehealth/telemedicine development act."

§ 2. The public health law is amended by adding a new article 27-M to read as follows:

ARTICLE 27-M

NEW YORK STATE TELEHEALTH/TELEMEDICINE DEVELOPMENT PROGRAM

Section 2799-t. Legislative intent.

2799-u. Coordination of department responsibilities for telehealth/telemedicine; annual plan.

2799-v. Telehealth/telemedicine development; grants for underserved areas and populations.

2799-w. Telehealth/telemedicine research.

§ 2799-t. Legislative intent. The legislature recognizes the demonstrated cost-effectiveness, improvements in disease management and improved patient outcomes resulting from the provision of telehealth/telemedicine services. Telehealth/telemedicine services are those services which utilize electronic technology over a geographic distance between patients and health care providers for the purposes of assessment, monitoring, intervention, clinical management and/or education with patients. Studies have chronicled significant reductions in hospitalizations and otherwise necessary medical care as a result of telehealth/telemedicine intervention. The legislature further recognizes that geography, weather and other factors can create barriers to accessing appropriate health and mental health care in New York state and that one way to provide, ensure or enhance access to care given these barriers is through the appropriate use of technology to allow health care consumers access to qualified health care providers and institutions. In order to promote the role and capacity of telehealth/telemedicine technology relative to these purposes, the legislature hereby enacts the New York state telehealth/telemedicine development act to establish a telehealth/telemedicine development program to coordinate and focus state administrative responsibilities as well as state policy and program planning for telehealth/telemedicine, provide for telehealth/telemedicine development in underserved geographic areas and for new populations, promote quality and safeguards in telehealth/telemedicine, promote and assist telehealth/telemedicine research and evaluation, establish the telehealth/telemedicine research and development fund, and provide for capital financing.

§ 2799-u. Coordination of department responsibilities for telehealth/telemedicine; annual plan. 1. The commissioner shall coordinate and focus the department's developmental, administrative, research and evaluation responsibilities for telehealth/telemedicine services.

2. The commissioner, in consultation with eligible providers as specified in subdivision two of section twenty-seven hundred ninety-nine-v of this article, shall prepare and submit an annual plan to support the provision of telehealth/telemedicine services provided pursuant to subdivision three-c of section thirty-six hundred fourteen of this chapter, as well as other telehealth/telemedicine services for which the department has developmental and administrative responsibility. The annual plan shall include:

(a) Any necessary recommendations for legislative, administrative or budgetary support for telehealth/telemedicine services;

(b) The identification of barriers to the provision of and access to telehealth/telemedicine, including education and training for both providers and consumers, electronic records interface, and other, and the methods by which the department will aid in addressing such barriers; and

(c) An abstract of telehealth/telemedicine research either being or to be conducted by the department, or facilitated by the department and being or to be conducted by providers or other entities.

3. The commissioner shall provide copies of the annual plan to the governor, the temporary president and minority leader of the senate and the speaker and minority leader of the assembly.

4. (a) The commissioner, in consultation with eligible providers as specified in subdivision two of section twenty-seven hundred ninety-nine-v of this article, shall identify standards determined to be necessary for telehealth/telemedicine services under this article. Such standards, including standards for the protection of patient information, shall be identified from:

(i) the American telemedicine association, the federal Food and Drug Administration and/or other generally recognized standard-setting organizations as the commissioner may determine;

(ii) title eight of the education law and regulations thereto, this chapter and regulations thereto and, as applicable, the standards of relevant professional or accrediting bodies as the commissioner may determine, to ensure that telehealth/telemedicine monitoring is conducted by individuals in accordance with, and as limited by, the applicable scope of practice, licensure and/or credentialing provisions of such laws and standards.

(b) The commissioner may incorporate, within the annual plan submitted pursuant to subdivision two of this section, recommendations for any additional standards or requirements for telehealth/telemedicine services as may be necessary under this article.

§ 2799-v. Telehealth/telemedicine development; grants for underserved areas and populations. 1. Subject to the availability of funding from section ninety-nine-t of the state finance law, funds made available in the general fund or any other funds made available therefor, the department shall provide grants to eligible providers for:

(a) the development of telehealth/telemedicine services in geographic areas of the state deemed by the department to be underserved on the basis of a lack of providers pursuant to this article;

(b) the development of telehealth/telemedicine services in geographic areas of the state deemed by the department to be underserved on the basis of the lack of telehealth/telemedicine services in the area;

(c) the development of telehealth/telemedicine services for new populations, where evidence suggests the provision of such services would facilitate the management of patient care, access to care and/or cost effectiveness of care;

(d) the development of telehealth/telemedicine services for new conditions, where evidence suggests the provision of such services would facilitate the management of such conditions, access to care and/or cost-effectiveness of care;

(e) the development of telehealth/telemedicine services to evaluate the potential benefits of new telehealth/telemedicine technology, for patient care, access to care and/or cost-effectiveness of care; or

(f) such other purposes as the department may identify.

2. Eligible providers shall include those licensed, certified or authorized under article twenty-eight, thirty-six or forty of this chapter or under section forty-four hundred three-f of this chapter or physicians licensed under article one hundred thirty-one of title eight of the education law; provided however that eligibility under this section to provide telehealth/telemedicine services shall be consistent with the authority for the provision of care otherwise provided pursuant to article twenty-eight, thirty-six or forty of this chapter or under section forty-four hundred three-f of this chapter or title eight of the education law.

3. The department, in consultation with eligible providers as specified in subdivision two of this section, shall establish the forms and process for the submission and approval of grant applications pursuant to this subdivision.

§ 2799-w. Telehealth/telemedicine research. 1. The commissioner shall promote and support clinical and programmatic research by providers and other entities to further evaluate, refine and/or develop

effective and efficient application of telehealth/telemedicine methods and technology to populations, conditions and circumstances. The commissioner shall make available data and technical assistance for such research, provided that any data made available must not contain individually identifying information.

2. The commissioner is authorized to apply for such governmental, philanthropic and other grants that may be available for such research. Monies from such grants shall be deposited in the New York state telehealth/telemedicine development and research grant fund established by section ninety-nine-t of the state finance law.

3. The department shall consult with eligible providers, as specified in subdivision two of section twenty-seven hundred ninety-nine-v of this article in the implementation of this section.

§ 3. Section 3614 of the public health law is amended by adding a new subdivision 3-d to read as follows:

3-d. Capital reimbursement for telehealth/telemedicine. The department shall include in the reimbursement rates established pursuant to this section a cost allowance for the reimbursement of capital costs for the development, operation and provision of telehealth/telemedicine services, including the linkage of telehealth/telemedicine and electronic medical records. The methodology for the inclusion of the allowance shall be developed in consultation with the eligible providers for telehealth/telemedicine pursuant to section twenty-seven hundred ninety-nine-u of this article.

§ 4. The state finance law is amended by adding a new section 99-t to read as follows:

§ 99-t. New York state telehealth/telemedicine development and research grant fund. 1. There is hereby established in the joint custody of the state comptroller and commissioner of taxation and finance a special fund to be known as the "New York state telehealth/telemedicine development and research fund".

2. Such fund shall consist of all monies appropriated for the purpose of such fund and any grant, gift or bequest made for purposes of development or grants for telehealth/telemedicine services pursuant to section twenty-seven hundred ninety-nine-v of the public health law.

3. Monies of the fund shall be available to the commissioner of health for the purpose of providing development and research grants for telehealth/telemedicine pursuant to section twenty-seven hundred ninety-nine-v of the public health law.

4. The monies of the fund shall be paid out on the audit and warrant of the comptroller on vouchers certified or approved by the commissioner of health, or by an officer or employee of the department of health designated by such commissioner.

§ 5. This act shall take effect immediately; provided that section three of this act shall take effect on the first of April next succeeding the date on which this act shall have become law; provided further however that the commissioner of health shall be authorized to take all necessary steps to implement this section by such date.

APPENDIX H

NEW YORK STATE TELEHEALTH/TELEMEDICINE DEVELOPMENT ACT BILL MEMO (S. 662-A/A. 3793)

SENATE BILL NUMBER: S662-A

ASSEMBLY BILL NUMBER: A3793

SENATE SPONSOR(S): Valesky

ASSEMBLY SPONSOR(S): Morelle

INTRODUCED AT THE REQUEST OF: NYS Legislative Commission on Rural Resources

TITLE OF BILL:

An act to amend the public health law, in relation to promoting the development, provision and accessibility of telehealth/telemedicine services in New York state; and to amend the state finance law, in relation to establishing a New York state telehealth/telemedicine development and research grant fund

PURPOSE:

This legislation would enact the "New York State telehealth/telemedicine development act" to coordinate and focus state policy and program planning for telehealth and telemedicine.

SUMMARY OF SPECIFIC PROVISIONS:

This legislation would add a new article 27-M to the public health law, creating the "New York State telehealth/telemedicine act."

Section 2799-u establishes a telehealth/telemedicine development program to coordinate and focus state administrative responsibilities and planning efforts relative to telehealth & telemedicine. This would involve the submission of an annual plan to the governor and legislature to include necessary recommendations for legislation, regulatory or budgetary support; the identification of barriers to the provision of an access to telehealth/telemedicine; an overview of relevant research being conducted.

The commissioner is also charged with identifying standards from the American Telemedicine Association, the Federal Food and Drug Administration, the public health law, the education law and other generally recognized standard setting or accrediting sources as the commissioner may determine necessary to ensure appropriate safeguards for the use of telehealth/telemedicine services are in place

Section 2799-v authorizes funding and grants for eligible providers for the development of telehealth/telemedicine services in underserved geographic areas in the state, and where it is determined that the implementation of such telehealth/telemedicine services would improve patient access and quality of care.

Section 2799-w directs the health commissioner to promote and support clinical and programmatic research to develop effective and efficient

application of telehealth/telemedicine methods. It also authorizes the commissioner to apply for govern-mental and philanthropic grants.

This legislation also amends the public health law to provide for the capital reimbursement for telehealth and telemedicine expenditures. It also creates the New York state telehealth/telemedicine development and research grant fund.

JUSTIFICATION:

One measure of a community's quality of life is the availability, accessibility and quality of its health care services. The Internet and other electronic technologies have the potential to fundamentally reshape health care service delivery in ways that improve quality of and access to care in a cost-efficient manner. Technology can bring cutting-edge health care to any location, help reduce and prevent medication errors and enhance information about state-of-the-art health care. Large segments of New York's population in rural and other medically underserved areas have difficulty accessing primary health care and specialty services as well as health education. Providers in these communities are often isolated from mentors, colleagues and information necessary to provide optimal patient care.

The proven potential of telehealth/telemedicine to both provide primary care access to underserved populations, as well as reduce hospitalizations of patients suffering from chronic disease, through the use of home care, warrants an increased focus on the application of such technology in our health care system.

The purpose of this bill is to serve as catalyst to expand and improve telehealth and telemedicine programs in communities across the State, through adoption of a state policy to direct telemedicine/telehealth health services in New York. Through an integrated telecommunications system, patients and providers across the continuum of care can have increased access to medical treatment and state-of the-art health care, as well as educational and professional training opportunities.

Congress has recognized these benefits in authorizing Medicare reimbursement for telemedicine services. However, the issues are more complex at the state level because each state has the authority to set its own requirements for licensure and credentialing, as well as different rules for insurance and Medicaid programs.

It is well established that New York spends far more on Medicaid expenses than any other state, per capita. The legislature must seek long-term solutions that look to maintain quality of care, while lowering the utilization of non-ambulatory health care services that increase cost borne by our taxpayers. Breaking down the geographic barriers between patients and providers through telecommunications must lie at the heart of this effort.

PRIOR LEGISLATIVE HISTORY:

2011: S.662 REPORTED AND COMMITTED TO FINANCE; A.3793 Referred to health
2009-2010: S3198-B REPORTED AND COMMITTED TO FINANCE; A.11415 Referred to health

*Similar legislation (A.1766-A of 2009) creating a telehealth/telemedicine task force passed the Assembly in 2009.

FISCAL IMPLICATIONS: To be determined.

EFFECTIVE DATE:

Immediately, provided that section three shall take effect the first of April succeeding the date on which this act shall become law.

APPENDIX I

HOME TELEHEALTH PRESERVATION AND INNOVATIONS ACT BILL LANGUAGE

AN ACT to amend the public health law and the insurance law, in relation to home telehealth access and innovation

The People of the State of New York, represented in Senate and Assembly, do enact as follows:

Section 1. Short title. This act shall be known and may be cited as the “home telehealth preservation and innovations act”.

§ 2. Legislative findings and declaration. The legislature finds and declares that telehealth has become a vital health care modality, enabling new and highly advanced methods of patient access and care management at home and in the community. Both empirical data and descriptive studies provide clear and mounting evidence of telehealth’s capacity for achieving improved patient outcomes, system-wide cost-effectiveness and overall improved institutional/non-institutional resource use.

The legislature finds that telehealth offers a means for critical patient monitoring, self-management and professional intervention for diverse conditions and circumstances, and that it benefits the patients and systems in rural, urban and suburban locations. Rural health care providers and patients, in particular, face a unique combination of factors that create access challenges to health care for which telehealth is especially vital.

As telehealth evolves to become a further core to the foundation of the health care system, the legislature finds that it is essential to address certain priority issues in telehealth access, operation and development in this state, and that such priority action must include ensuring telehealth continuity and progression in the context of the state’s current and rapid transition to managed care. The legislature finds that areas to be addressed in such a policy framework should include, but not be limited to: continuity, adequacy and integration of telehealth reimbursement; continuity of telehealth services and operation; removal of barriers to access for unserved and underserved populations; telehealth innovation in relation to technology, populations, delivery options and research; and telehealth coverage within the state’s long term care and health insurance policies.

The legislature therefore declares that, given this technology’s far reaching possibilities for the improvement and efficiency of the state’s overall public health and health delivery systems, the enactment and implementation of this act be a priority focus of the state’s actions.

§ 3. Subdivision 1 of section 2 of the public health law is amended by adding five new paragraphs (o), (p), (q), (r) and (s) to read as follows::

(o) “Distant site” means a site at which a health care provider is located while providing health care services by means of a telecommunications system.

(p) “Health care provider” means a health care provider as defined in section two hundred thirty-eight of this chapter.

(q) “Originating site” means a site at which a patient is located at the time health care services are provided to him or her by means of a telecommunications system.

(r) “Telehealth” means the mode of delivering health care services by means of information and communications technologies including, but not limited to, telephones, facsimile machines, electronic mail systems, remote patient monitoring devices or other electronic means which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self management of a patient’s health care while such patient is at the originating site and the health care provider is at a distant site. Such term shall include telemedicine as defined in this act.

(s) “Telemedicine” means the delivery of clinical health care services by means of real time two-way electronic audio visual communications which facilitate the assessment, diagnosis, consultation,

treatment, education, care management and self management of a patient's health care while such patient is at the originating site and the health care provider is at a distant site.

§ 4. Subdivision 3-c of section 3614 of the public health law is amended by adding three new paragraphs (e), (f) and (g) to read as follows:

(e) Telehealth services and reimbursement for such services provided to certified home health agencies, long term home health care programs and AIDS home care programs, and licensed home care services agencies under subcontract with such agencies or programs, shall continue to be provided pursuant to this subdivision notwithstanding the provisions of subdivision thirteen of this section, subparagraph (i) of paragraph (b) of subdivision seven of section forty-four hundred three-f of this chapter or paragraph (e) of subdivision three of section three hundred sixty-four-j of the social services law.

(f) Notwithstanding any inconsistent provision of this article, the commissioner is authorized to approve reimbursement under this section to promote and test the clinical benefits and cost-effectiveness of additional innovative applications of telehealth including, but not limited to:

(i) telehealth uses in the care of new or underserved populations, including in the case of underserved populations those with access challenges due to geography, physical or mental/behavioral condition, confinement to home, ethnic/cultural barriers, palliative care needs, or other factors deemed appropriate by the commissioner;

(ii) provision of telehealth as a distinct and separate care management service from the home care agency's home care program, for individuals whose remote monitoring needs may be met through telehealth and without provision of such other services; provided that the commissioner shall be authorized to seek or provide such waivers as may be necessary for this purpose;

(iii) the use of telehealth kiosks for monitoring, preventative and health education services located in community settings by home care agencies where identified populations in need are likely to access and use these services; and

(iv) such other demonstration purposes consistent with this paragraph as the commissioner may determine.

In order to assist the commissioner in testing the provisions of this section, home care agencies approved to provide such innovations shall track and report the results for purposes of telehealth research and for determining broader applicability and/or benefit to the patients, the health care system and the cost-effectiveness of care.

(g) To facilitate access to telehealth services in geographic areas determined by the commissioner to be unserved or underserved, the commissioner is authorized to approve a telehealth service area for a certified home health agency, long term home health care program or AIDS home care program that extends to such unserved or underserved areas, notwithstanding the geographic parameters of the normal service area that is otherwise approved for other home health services provided by the agency.

§ 5. subdivision 10 of section 4403-f of the public health law, as amended by section 41-b of part H of chapter 59 of the laws of 2011, is amended to read as follows:

10. Notwithstanding any inconsistent provision to the contrary, the enrollment and disenrollment process and services provided or arranged by all operating demonstrations or any program that receives designation as a Program of All-Inclusive Care for the Elderly (PACE) as authorized by federal public law 105-33, subtitle I of title IV of the Balanced Budget Act of 1997, must meet all applicable federal requirements. Services may include, but need not be limited to, housing, inpatient and outpatient hospital services, nursing home care, home health care, adult day care, assisted living services provided in accordance with article forty-six-B of this chapter, adult care facility services, enriched housing program services, hospice care, respite care, personal care, homemaker services, diagnostic laboratory services, therapeutic and diagnostic radiologic services, emergency services, emergency alarm systems, home delivered meals, physical adaptations to the client's home, physician care (including consultant and referral services), ancillary services, case management services, transportation, and related medical services. Such services may also include home telehealth services provided and reimbursed pursuant to the provisions of subdivision three-c of section thirty-six hundred fourteen of this chapter provided

however that the commissioner may also authorize the reimbursement for such services pursuant to this section, but subject to approved providers, criteria and reimbursement levels pursuant to such subdivision three-c.

§ 6. Paragraph (a) of subdivision 3-c of section 3614 of the public health law, as added by section 63-b of part C of chapter 58 of the laws of 2007, is amended to read as follows:

(a) Demonstration rates of payment or fees shall be established for telehealth services provided by a certified home health agency, a long term hone health care program or AIDS hone care program, or for telehealth services by a licensed home care services agency under contract with such an agency or program, in order to ensure the availability of technology-based patient monitoring, communication and health management. Reimbursement for telehealth services provided pursuant to this section shall be provided only in connection with Federal Food and Drug Administration-approved and interoperable devices, and incorporated as part of the patient's plan of care; provided however that reimbursement may also be provided by the commissioner, subject to the approval of the director of the budget, for further innovations in telehealth delivery pursuant to paragraph (f) of this subdivision. The commissioner shall seek federal financial participation with regard to this demonstration initiative.

§ 7. This act shall take effect immediately, provided, however, that the amendments to subdivision 10 of section 4403-f of the public health law made by section five of this act shall not affect the repeal of such section and shall be deemed repealed therewith.

APPENDIX J

HOME TELEHEALTH PRESERVATION AND INNOVATIONS ACT BILL MEMO

SENATE BILL NUMBER:

ASSEMBLY BILL NUMBER:

SENATE SPONSOR(S): YOUNG

ASSEMBLY SPONSOR(S): Gunther

INTRODUCED AT THE REQUEST OF: NYS Legislative Commission on Rural Resources

TITLE OF BILL:

An act to amend the public health law, in relation to home telehealth access and innovation.

PURPOSE:

Enacts the "home telehealth preservation and innovations act."

SUMMARY OF PROVISIONS:

Section 1 states that the act shall be known as the Home Telehealth Preservation and Innovations Act.

Section 2 states the legislative findings and declaration.

Section 3 amends subdivision 1 of section 2 of the public health law to include definitions for "distant site," "originating site," "telehealth," and "telemedicine."

Section 4 amends subdivision 3-c of section 3614 of the public health law by adding three new paragraphs. Paragraph (e) provides for continuity of telehealth - including continuity of reimbursement, continuity of service and continuity of procedure for home telehealth services provided by certified home health agencies, long term home health care programs and AIDS home care programs, and licensed home care services agencies in the transition to episodic payment; managed long term care and mainstream managed care.

Paragraphs (f) and (g) will foster opportunities for innovation and access in home telehealth programs by expanding the Commissioner's ability to reimburse for additional telehealth applications.

Section 5 amends subdivision 10 of section 4403-f of the public health law by adding telehealth to the list of services covered by managed long term care programs, carrying forward the reimbursement, providers, services and procedures of the current established program. In addition, the Commissioner is permitted to reimburse such services either separate from the managed long term care payment, or within the payment.

Sections 6 amends paragraph (a) of subdivision 3-c of section 3614 of the public health law (the telehealth program) to permit the Commissioner to provide reimbursement for innovations in the delivery of telehealth in accordance with paragraph (f).

Section 7 states the effective date.

JUSTIFICATION:

Home telehealth services have and continue to be a cost effective way to provide critical monitoring and care to patients faced with significant impediments due to geographic isolation and/or limited health care access.

This legislation is needed to ensure that this important service remains available to rural patients during and after the implementation of episodic payments, managed long term care and mainstream managed care. It is especially important in light of the significant reductions that home care programs have faced during the past three budget cycles.

Home care has faced significant reductions in funding which have directly impacted the patients who rely on these services to ensure that their conditions remain stable.

LEGISLATIVE HISTORY:

New Bill.

FISCAL IMPLICATIONS:

Undetermined.

EFFECTIVE DATE:

Effective immediately.