COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
HOUSE INSURANCE COMMITTEE

STATE CAPITOL
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TUESDAY, APRIL 15, 2008
10:00 A.M.

PUBLIC HEARING ON
HOUSE BILL 1849

BEFORE:

HONORABLE ANTHONY M. DELUCA, CHAIRMAN
HONORABLE SCOTT W. BOYD
HONORABLE RON BUXTON
HONORABLE JOHN R. EVANS
HONORABLE ROBERT W. GODSHALL
HONORABLE BOB MENSCH
HONORABLE STEVEN R. NICKOL
HONORABLE RICK TAYLOR

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ALSO PRESENT:

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REPORTER - NOTARY PUBLIC

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P R O C E E D I N G S

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CHAIRMAN DELUCA: Good morning, ladies and gentlemen. I -- it's ten after. We apologize. We were looking to see our first testifier, who got tied up on the expressway coming in from Philadelphia today, so I -- he said he'll be a little late, but we're going to start the meeting since it's ten after.

Before I start, I'd like to have my colleagues introduce themselves from my left.

REPRESENTATIVE BUXTON: Ron Buxton, Dauphin County.

REPRESENTATIVE GODSHALL: Bob Godshall, Montgomery County.

REPRESENTATIVE NICKOL: Steven Nickol, York and Adams.

REPRESENTATIVE MENSCH: Bob Mensch, Montgomery County.

CHAIRMAN DELUCA: I'm Representative Tony DeLuca, the Chairman from Allegheny County.

REPRESENTATIVE EVANS: John Evans from Erie and Crawford Counties.

REPRESENTATIVE BOYD: Scott Boyd from Lancaster County.

CHAIRMAN DELUCA: Okay. And as I said this morning, I want to thank everyone for coming out today to -- for these hearings. The Insurance Committee is going to be having a lot of hearings on different pieces of legislation to -- to educate not only ourselves but to educate the public.

And today, this morning, we have House Bill 1849 sponsored by Representative Mark Cohen dealing with the coverage for telehealth care services.

Telehealth is defined in the bill as a remote interaction between a health care professional and a patient through the use of video cameras and transmission on a computer or other devices that deliver health information concerning the patients to a health care professional.

As technology evolves, the practice of medicine must advance along with it. It is incumbent upon us to investigate and consider these technologies -- technologies and advances and how they can benefit our

constituents.

The telehealth benefits as envisioned in the legislation would have to be appropriate for the patient and the use of these tools would have to result in lowering health care costs. This would appear to be a -- a win/win situation for the patient and certainly for the insurance companies.

The use of this new technology is designed to reduce the traditional necessity of patients going to the doctors' offices for health care monitoring.

Patients can be provided with information on how to self-manage their health concerns. It would appear that the use of telehealth medicine would be more convenient for both the providers and the patients. It also seems connecting the patients with health care through these devices would reduce the demands for health care services and save the patients time and money going for the doctors' visits.

I understand that telehealth is paid for in at least five states -- Louisiana, Kentucky -- California, Oklahoma, Texas and

Kentucky. Although it is permitted in Pennsylvania, it is not often reimbursable expenses by the insurance companies.

I hope this hearing will enlighten the committee as to the efficacy of the use of telehealth care, and we will be able to determine whether or not it makes sense in this state.

At first glance, it appears using such technology may, in fact, be a good idea, but I need to hear more about it and this committee needs to be -- hear more about it as to how it actually is used and to learn if it's a safe and reliable alternative to physically seeing one's physician.

Again, I would like to welcome all of you to our hearing today, especially those of you who have -- who will be testifying. I look forward to hearing your thoughts on this legislation so that we can educate the committee and educate the members here.

Before I start, I want to apologize -- not apologize but I want to relay the fact that the chairman, my good friend Representative Micozzie, unfortunately

couldn't be here today because he had something in his district. It's election time, and unfortunately he had something to do in his district and had a couple meetings there and he couldn't get out. So he just wanted to relay that to the members and relay it to the audience.

So without further ado, we'll call our first -- or the second testifier, Andrew Watson. He's an M.D. with the University of Pittsburgh Medical Center. Welcome him.

DR. WATSON: Chairman DeLuca and other distinguished members of the House Insurance Committee, I want to thank you for giving us the opportunity to come here and speak about House Bill 1849 on behalf of UPMC.

At UPMC our mission is to provide high-quality and cost-effective health care for our patients, and we believe, and firmly believe, that removing barriers for telemedicine will help us to accomplish this goal.

Just a bit about why I'm here. I'm an actively practicing laparoscopic surgeon.

In my practice I'm actually a fourth generation surgeon in Pittsburgh. My great-grandfather, grandfather, great uncle and father were all surgeons in Pittsburgh. And when I started my training, what I particularly do benefits from technology.

When I trained, I was trained in open surgery. These days we do laparoscopic surgery. And if you've heard of laparoscopic cholecystectomy, which is minimal access techniques for taking out your gallbladder, it's incredible the effect it has on patients every day.

This is now standard of care for this country. If you were to go to somebody's office and they wanted to take out your gallbladder through a large incision, that would probably scare you away from them.

Colon surgery is what I do. I can take out someone's colon, and I say that humbly, through a incision about an inch and a half long, two inches. The patients are out of bed that afternoon, go home in several days. It's incredible. They have less problems with wound healing, hernias, faster

return to work, and less pain.

Every day that I live with my practice, I'm looking at the benefits of technology, what it's done for health care and patients and every day I appreciate it more and more. It's -- it's with this background that I became interested in telemedicine, looking at how technology will benefit patients.

I'm here on behalf of Lawrence Wechsler, who is the head of the UPMC Center for Telehealth, and I'm an associate director as well, as well as our Physician Services Division.

The -- our view of telemedicine and telehealth is it's a way of connecting patients and physicians, as well as diagnostic testing, when all those pieces of information and parties may be physically separate.

Patients can be in the south side, the physicians can be, for us, in the city of Pittsburgh itself, and the information could be from Erie, it could be from somewhere else, where that patient may have been transferred from, and we believe it's telemedicine's way

of looking at patients and seeing patients and evaluating through these very disparate sites.

The -- it's incredible the revolution of technology that we've seen. These days patients have to travel to specialists in the centers of care. We've come to know health care as being these large academic centers of excellence. Patients have to drive hours, families have to take time off work to drive, and there's the costs associated with this as well.

And we believe that telemedicine is a way of actually reversing that process.

The technology has changed enormously. I mean these days we have cell phones that are as commonplace as cars, this is broad-band connectivity, and we think telemedicine is a way to turn this around so that we can go back to the patients.

Patients don't necessarily want to come to the hospital just to have a wound checked or to have the heart listened to. We can do this just as effectively and safely through telemedicine.

I had some problems believing this -- I'll be very honest with you -- up-front, but I went down to Texas and heard an electronic stethoscope and I watched them examine a patient 200 miles away.

And having been in medicine and medical school since 1993, so about 15 years into this, I'd never heard a patient's breath sounds so clearly as I did through a digital stethoscope and I'd never heard heart tones that clearly and it was incredible the effectiveness of being able to examine these patients remotely.

In many areas of Pennsylvania, as you well know, we have one of the country's largest rural populations with two very large cities on either end of the state. We have one of the sixth largest, I think, populations in the country right now.

It's very challenging to recruit surgeons and other specialists to Pennsylvania, as we know. So, therefore, patients are having to drive farther and farther to see the specialist.

And it's our position that we believe

that telemedicine is a way of providing high quality, as well as cost-effective, health care to these patients. We can take the health care back to the patients.

We had a tremendous grass roots appeal at UPMC for telehealth. We had a number of physicians come forth expressing interest in telemedicine or telehealth, both of those terms.

We had folks, ophthalmology, cardiology, radiology, wound healing, all come forth, as well as stroke in particular, saying that they wanted to look at ways of sort of centralizing telemedicine for UPMC.

And we, therefore, completed the UPMC Center for Telehealth, and we currently have 91 members. We have 31 divisions that it encompasses and we have committees looking at technology, outpatient care, looking at business plans, as well as ways to implement telemedicine to make it effective.

UPMC itself is one of the nation's largest integrated health care systems, as you know. We have about 48,000 employees, 20 hospitals, about 4.5 million outpatient visits

a year.

So we think that we've got an excellent delivery model for telemedicine as well. If I can give you some examples, telestroke is one of the most striking examples that I've personally seen of this. I'll give you an example of it. It happens quite frequently.

Imagine that if you have a stroke and you're out by UPMC Northwest. It's about an hour and a half drive down to UPMC Presbyterian. To treat a stroke, you need to have a clot-busting drug called tPA.

And what's critical about tPA, to give this clot-busting drug, it has to be given by and large by a trained specialist. Those specialists are not always immediately available at some of the other hospitals outside of the large tertiary hospitals.

And so to give -- make the call to give the clot-busting drug, the patient only has a very narrow window. If you go beyond that window, the patient can't get it and you lose the benefits of it.

And what we've learned, if somebody

comes in with a stroke and goes to the emergency room, and instead of having to drive an hour and a half to Pittsburgh, or get in a helicopter, and the helicopter may not be able to fly because of the weather, we can now turn on the telemedicine devices, someone can see the patient, interact with the patient, talk to the staff, examine the patient, and then make the decision to give the clot-busting drug, the tPA.

And the results actually are fairly spectacular. It's not a panacea, but there are a number of cases where patients' neurologic symptoms can resolve right there in the emergency room.

And the impact of this is tremendous. Because if you go on to complete a stroke, so to say, you can end up in rehab. You could not be able to return to work. You could end up in a prolonged hospitalization and have all the associated complications and all the procedures that may go along with that.

But by having a trained specialist available at any time, no matter where you

are, to be able to make the decision to give you the clot-busting drug is tremendous.

We have 14 hospitals enrolled with us now. We've treated 165 patients currently with the tPA, and the interesting thing about that is our rate of treatment with tPA is about 25 percent.

So a quarter of the patients that come in are candidates for tPA and they're getting it. And what's interesting is the national average for giving tPA is three percent. So we've seen a 20-fold or 20 percent increase in giving tPA where it's indicated.

And on a national level this has been shown to give tremendous cost savings. I'll mention that just a little bit later on.

One of the other programs that we're also looking at is telepsychiatry. There's a enormous dearth of psychiatrists in the state of Pennsylvania as well.

We currently have a program that's being developed through our UPMC health plan looking at a pilot program to deliver psychiatric care to adolescents and young

adults through the use of telemedicine.

The kids actually love this. If you think about the way folks interact these days with cell phones, video games or televisions, they actually feel more secure looking into the camera and talking to the television screens, if you can believe it.

And I think it was surprising for us to hear that as well.

But this is a way of reaching out to patients who are -- can be a hundred miles away through the use of telemedicine to give them meaningful psychiatric care where otherwise it may not have been available.

The impact of that on these kids, as well as the communities and families that support them, is tremendous.

And the third example of something that we do currently at UPMC is wound care. Currently there are not many wound care specialists in the state of Pennsylvania. We're fortunate to have Dr. David Steed, who's a wound care specialist on staff in Pittsburgh, and he has the ability to look at folks that might have chronic, non-healing

lower extremity wounds. For folks that have diabetes or heart failure or venous insufficiency, a lot of times, it's very hard for these people to drive or travel an hour to an hour and a half to have their wound evaluated.

And what we've been able to do at UPMC is have specialized nurses go in there with cameras to take pictures of the wounds.

When you look at the wound, those pictures can be sent back to Dr. Steed, who might be 50 or 100 miles away. He can evaluate the wound. He can determine the treatment and prescribe the treatment and then follow the wound through remote technologies.

And what he's finding right now -- and these results are unpublished, but we're looking at this also with the UPMC health plan -- is that the rate of healing for wounds is much faster and the time of open wounds is actually decreasing.

One of the issues around telemedicine, we talk about the patient care, which we believe we can accomplish. We think it's effective. But the cost effectiveness of

telemedicine is an issue for all of us and the cost of health care is an issue for all of us.

There was a landmark study released. It's in the papers that we provided you folks. It was released this November by the Center for Information Technology Leadership, and it's a report entitled The Value of Provider-to-Provider Telehealth Technologies.

This was a collaborative venture by AT&T and through a nonprofit venture in Boston looking at the impact of telemedicine on this country.

I should say the background for this report was the University of Texas medical branch in Texas. They've done half a million telemedicine consults. They do 70,000 telemedicine consults a year within the state. They have 25 rooms going simultaneously all day long looking at telemedicine, and it's incredibly effective. And this is what the basis of this report came from.

But this report is looking at nursing homes, emergency rooms, especially prison

care, and what they're finding right now is they're projecting that there could be an annual savings of about $4.4 billion in health care revenue due to the use of telemedicine.

The Journal of Stroke -- getting back to strokes just for a second -- talking about giving the clot-busting drugs, they're looking at the savings of giving tPA. So if you give the clot-busting drug and the patient is able to walk out of the hospital and not go to rehab, return to work, there are tremendous savings that they're realizing.

The national average, again, is about two to three percent of giving tPA. Our rates through the use of telemedicine at UPMC are 25 percent and what the studies have shown -- again, I put the references in here for you -- is that if you increase the use of tPA by 20 percent in this country, the health care savings estimate is approximately $74 million. And at UPMC we're actually achieving the 20 percent rate right now.

And to summarize, we recognize that Pennsylvania is one of the largest and most rural states in the country. We've got some

tremendous challenges here.

I'm a young surgeon. I've watched a lot of my colleagues. We've had problems recruiting folks and retaining folks as well. It's hard to get specialists out to the underserved communities and to the rural areas, and this could be a problem for Pennsylvania. We have an aging population as well.

I spend my weekends out in Punxsutawney where I hide from medicine and my wife tolerates me being out there and taking care of some groundhogs.

But out there, when you talk to the folks out there, they can't -- they don't want to drive to Kittanning. They think Kittanning is a big city. They don't want to come down to Pittsburgh.

Parking in Pittsburgh is excruciating. And so for patients, they don't want to come to the big cities. They'd rather go to their local health care clinics or even stay in their homes.

And we believe that we can use telemedicine to go back to old-fashioned

medicine, go back to their homes. Their homes can have devices where it can tell what pills they've taken, their homes can tell how much they weigh, what their blood sugars are, and this data can get fed back to the patient's physicians as well as back to nurses that can monitor this.

We're very appreciative of the efforts of this committee and of the Pennsylvania legislature in general for looking at telemedicine and considering this.

UPMC is a leader in the field of telemedicine and we're very excited about this. We are convinced that it's going to have a very strong impact on the cost effectiveness of patient care.

We believe that it delivers high quality patient care that all Pennsylvanians deserve. It's going to help to remove some of the barriers of telemedicine, and we believe that the House Bill that you've introduced here is a great start for us in many ways to look at removing the barriers of telemedicine that we think is so important.

Thank you very much.

CHAIRMAN DELUCA: Thank you, doctor. Let me ask, since you mentioned the fact that we're looking at cost and we are trying to lower costs, what are the statistics in the states that I read off, Louisiana, California, Oklahoma, Texas, Kentucky? Have they saved money by introducing this legislation? I mean paying for these type of procedures, telemedicine?

DR. WATSON: I can't tell you on a statewide level, sir. What people are looking at right now -- because telemedicine, this next generation of telemedicine that we're seeing in the last three or four years came about with the advent of technology. Look at YouTube, iPhones, portability of video, and broad-band connectivity.

I don't think that we have a state number that I'm aware, but I could be wrong about that. But in terms of specific projects, like the stroke that I've talked about, you're looking at congestive heart failure, monitoring the patients at home, folks with chronic diseases at home such as diabetes, those they are seeing significant

cost savings.

But it makes sense. I mean if you can -- if you have an 80-year-old patient that has heart failure and every day you're seeing their weight, seeing what medications they took, looking at how much their blood sugar was, when you start seeing the numbers go awry, you can intervene earlier rather than waiting a week or two and having them show up in the ER with decompensated heart failure.

It's a whole new way to connect to patients at home.

CHAIRMAN DELUCA: And tell me how this works. I imagine the individual would have to have a camera?

DR. WATSON: There's a couple ways you can do this. Are we talking about at the home or in the clinic, sir?

CHAIRMAN DELUCA: I imagine I'm talking about at home.

DR. WATSON: The way it works at home, there's several ways you can do it. They make Bluetooth devices -- this is the wireless headsets, wireless connections, Bluetooth that we use.

What you can have is the scale commit -- transmits wirelessly to a device. The pill dispenser, every time they take a pill, it sends the information to the device. When you check your finger sticks to see what your glucose is, that also likewise goes to the device.

You can even have their exercise cycle, if you want to become more sophisticated, connected to the device, and that device can hook up to their cable box, cable TV.

And then so the nurses -- that data is fed back to the central monitoring facility, be it the hospital, on a daily basis, and you can have your staff members look at that and say this person has congestive heart failure. Their weight's going up. They're not taking their pills. Clearly something is going wrong. We need to call them and intervene now so they can stay at home rather than making the family take time off work or incurring the expense of bringing them into the hospital to manage this.

CHAIRMAN DELUCA: Okay. The other thing you brought up, doctor, as we look at costs, you mentioned the fact of laparoscopic surgery and that there.

How do we get the medical profession to adopt some of these new procedures?

And I'll give you an example. I had a new knee replacement, and I had the minimally invasive procedure. There's quite a few very top orthopedic specialists in Pittsburgh who unfortunately don't do the new procedure.

Now, I was out in one day. My brother had the same sickness, same surgery, had the other procedure, the old type procedure, and he was in the hospital for two-and-a-half days.

The costs -- we are trying to drive down costs. Why haven't we -- why haven't the surgeons adjusted to the new technology? Is it because they have to go back to school and learn it?

DR. WATSON: You hit the nail on the head. I was one of the first ones to do laparoscopic colon surgery in Pittsburgh, and

they would have thought I would have carried a pitchfork, had a forked tail or scales, or was some foreign creature because they thought it was heresy.

It takes awhile for people to understand the changes, and there is the fear of having to retrain. Because if you have to go back and take five or six months off your practice to learn a high tech new technology, it's very hard for folks to adopt to the new technologies in their practice.

But telehealth is somewhat different because you're not changing the way you practice or the tools that you practice with. It's just the way you talk to folks. And you could talk to them through cameras. You can interact with highly trained health care professionals at the remote site, have a nurse examine them, have a nurse look at the wound.

Orthopedics is a great example. Instead of having patients sit in the high risk hospital for five or six days after surgery looking at their wound, which is all you're doing, they can be sent to the rehabilitation facilities within one to two

days and there the orthopedic surgeons can use a camera to look at the wound and assess it to make sure it's not infected or then make sure it's healing well.

But the patients spends three or four less days in the hospital, goes to rehab right away, and so they're getting to rehab, back to work faster, but still being seen by the surgeons.

CHAIRMAN DELUCA: Okay. Thank you.

Oh, Representative Taylor is here. Representative Taylor just joined us.

Any questions on my left?

REPRESENTATIVE TAYLOR: I have a question.

CHAIRMAN DELUCA: Representative Taylor.

REPRESENTATIVE TAYLOR: Thank you, Mr. Chairman.

Thank you, doctor, for testifying today. So I understand that this bill has two purposes. One, to make health care more accessible. Right?

DR. WATSON: Correct.

REPRESENTATIVE TAYLOR: And, second,

drive down the costs of health care. So let me understand this. If -- if you can do this from Pittsburgh and Punxsutawney was the example you gave, it could be done in, let's say, in the Asian Pacific area or something like that, could the same procedure be done? Would it be possible to do that?

DR. WATSON: Health care has been defined by regions and geographic boundaries, how far you can drive. All those are going to disappear.

UPMC right now is -- strategically we look at the Cleveland Clinic, for example, which is one of our main competitors, but we'll be competing with the University of Miami as well as UCLA.

It can be done anywhere. The only small, technical glitch is the farther you go there's a slight lag. But we do teleconferencing all the time and I've seen it in some of your offices. You've got teleconferencing devices. In a lot of ways that's what it is. You use some specialized equipment, but you can communicate with patients at great distances.

The one I saw was 300 miles away and it was absolutely mind blowing to watch this and how effective it was.

REPRESENTATIVE TAYLOR: So with the idea of driving down health care, could it be the fact that a doctor in Pittsburgh would be more expensive than a doctor, let's say, in India, would that be the case, and if you're to drive down health care, that could be one way to do it?

DR. WATSON: Well, the issue there really is licensing in that out-of-state licensing is an issue and that we have to have licensed physicians to do this.

And to be licensed at any state in the United States, you have to have gone through the United States medical training.

What some states have done is they have telemedicine -- telemedicine licensing. I think Texas is one of them, too, sir, that physicians from one state can help to do medicine in another state.

But out of the country, at this juncture that I'm seeing, especially with these interactions, you'd have to be board

eligible or a board certified physician.

REPRESENTATIVE TAYLOR: So the global market could apply but not necessarily here because of the license? Is that what I hear?

DR. WATSON: I think the global market could apply. I don't think people -- people could not come in legally from the outside and do this from the outside.

There's going to be outreach from Pennsylvania physicians to other regions outside of the country, but it's not legal to do the reverse because of licensing reasons.

REPRESENTATIVE TAYLOR: Just to be clear, I applaud the idea of making health care more accessible to folks who might otherwise be denied, like the examples you gave in the rural areas, so this is what I'm trying to get at, is mostly trying to understand will we be losing doctors or, you know, putting doctors out of business and in a state where we already have --

DR. WATSON: Yes.

REPRESENTATIVE TAYLOR: -- a difficult job retaining doctors?

DR. WATSON: You know, I'll give you

an example that's interesting. That we went to a hospital in the UPMC system and I was a bit leery. It was the first time that we had spun telemedicine at one of our big rural UPMC hospitals and their response was overwhelmingly favorable.

And they gave us an example of they had a physician out there who was a young surgeon. And having just been a young surgeon, and I still am a relatively young surgeon, that it's a bit -- it's a bit scary the first year or two that you're out in practice because you're all alone. The safety net's gone. You're on your own.

And he was out there an hour and a half away. And the other surgeon who worked with him, they didn't get along very well, so he basically had very little back-up.

In this way, we could do teleproctoring where if this person had a question or needed some advice, we could put cameras in the wound, we could communicate with him to help decrease converting someone from laparoscopic procedure to an open procedure, shorten the OR times, and make sure

the surgery is done just as well.

I would love to partake in telementoring, help folks out there remotely.

REPRESENTATIVE TAYLOR: Okay. Thank you very much.

Thank you, Mr. Chairman.

CHAIRMAN DELUCA: Thank you.

Representative Mensch.

REPRESENTATIVE MENSCH: Doctor, good morning. Thank you.

I think it's a great idea. I come from an industry of high tech so any way that we can shrink the distance between the patient and the doctor I think is a really good idea.

But I do have a couple of questions, and some of them I think might also go, I think, to ultimately to the prime sponsor of the bill.

But let's talk about the initial cost, getting started in telemedicine. Most of the equipment, I would think, is already fairly common equipment in the hospitals or are you making major investments in new equipment per -- per incident? An incident would be you set one up, the practice next to

you setting one up, and so forth. What kind of costs are we talking about?

DR. WATSON: It depends on what you want to be, and I don't mean to hedge that much. But to be honest with you there are capital costs that we know exist buying the equipment. The price of the equipment has come down, I would say, by 50 percent so far with the new vendor in the market.

The main ones that people use are Polycom and Tandberg and Life Science. But it's no different than looking at the wiring even in the -- even in this facility here or the hospitals. These enormous infrastructures have been built to support the E-records, computers, the flow of information through hospitals. We're piggyback on the most -- we're piggybacking on the most expensive aspect of this, which is really the broad-band connectivity to do this.

You have to design devices to interact with folks, and that's what folks -- that's what we're developing right now and companies are.

So it might be a video camera. You

can use a $50 USB camera at some levels, but there are sophisticated devices that you can install. You can install a telemedicine table that sits in the ER and, therefore, if a patient comes in in congestive heart failure, you can listen to their lungs with an electronic stethoscope. If they have a lesion on their arm, you can take a picture of it. So it can be multi-purpose.

The goal is to combine all these efforts together which is why we have our Center for Telehealth to use the same equipment so it's not redundantly being purchased.

But the biggest investment, I think in my mind, has been paid for with the actual physical backbone that carriers like -- that Windstream or Alcatel or Alltel or Verizon have done for us.

REPRESENTATIVE MENSCH: Okay. So that's already being built as a matter of looking at the infrastructure in the country, the cost for the hospital.

But for the equipment, are we talking 10,000, 20,000, a 100,000?

DR. WATSON: If you want to do simple face-to-face teleconferencing, like what psychiatry does, you can buy the equipment for about 3 or $4,000 and get a simple Polycom device doing point-to-point calling.

If you want to get -- they make a portable suitcase which you can put into an overhead compartment. That's $50,000.

And so if you're a home care nurse in Pennsylvania, you can take this around and go to a patient's house and you can transmit the patient's breath sounds, heart tones. You could look at their -- their tonsils. You can take pictures of skin lesions. And you could wirelessly, through a satellite uplink, broadcast this back to the physician's offices or the hospital. That's $50,000 to do that.

And then if you think about it, if you save five or six admissions a year, you might even pay for it using that device alone.

The telemedicine table's around, the telemedicine suites is about 50,000 to 55,000 and that can be used for almost any speciality.

REPRESENTATIVE MENSCH: Two more quick questions. Broad-band, have there been any incidents when broad-band isn't available?

Let's say a diagnosis is in progress and you lose the broad-band connections, are there any legal ramifications?

DR. WATSON: We haven't encountered any yet. And what a lot of folks do and the important thing about telemedicine is to make sure you set it up and set it up so it works and works correctly.

In the last several years, the explosion of broad-band has meant incredible connectivity and very few dropped calls. I think if there were going to be large hospital connections so if UPMC Presbyterian is dealing with UPMC Northwest, with a very large tele -- telemedicine network, there's actually redundancy built into those connections. So if one circuit goes down, you just pick it up on the other.

REPRESENTATIVE MENSCH: One last question. In the -- in the bill, it enumerates several conditions that an insurer

needs to be satisfied with the medical facility. It says -- the third point is that the use of telehealth will result in lower health care costs than if it were not used.

How do we make that evaluation?

DR. WATSON: That is very difficult. I think it's going to be hard for us to say. I don't think we have encountered that before in medicine.

I've personally never seen that in my practice, being asked to say outright how much I saved doing laparoscopic surgery.

But I think we're beginning to look at these very specific programs, like stroke, where it shows that if the person gets the clot-busting drug within a half an hour versus four hours they don't go to rehab. They can start working in two weeks rather than spending their life not being able to work because their left side of their body doesn't work anymore.

I think it's in instances like that we're going to see the cost savings. Can the physicians document it up-front? I -- I'd be concerned about the physician doing it.

I think that concerns me tremendously because I never had that placed on me before.

But I think that we're going to have to. Hopefully with this committee. I'd be happy to come back here any time and provide as many examples as you would like to show that specific projects and pilot projects that we do, in conjunction with our health plan and other payers as well, show how these benefit these patients.

REPRESENTATIVE MENSCH: Thank you very much, doctor.

CHAIRMAN DELUCA: Representative Boyd.

REPRESENTATIVE BOYD: Somewhat on the same line as Representative Mensch's questions.

How much specifically has UPMC invested in this program so far?

DR. WATSON: In the Center for Telehealth?

REPRESENTATIVE BOYD: Yeah.

DR. WATSON: The biggest investment that UPMC has done to support this and the hospital in general is that it just signed a

$300 million deal with Alcatel-Lucent to upgrade its backbone.

We're talking up to a hundred megabit backbone up to a 10 gigabit fiberoptic core backbone. And what that's going to do is provide the ability that we can route high band with signals throughout our health care system.

Currently the ring, the fiber ring, includes the hospitals within the city of Pittsburgh. We're going to be building this out, not necessarily the fiber ring, but building a lot of the infrastructure upgrades out in the next -- three to five years is the roll out. That's the heaviest investment we have.

And what we're doing now is looking at vendors and trying to establish ways we can have purchasing agreements with vendors, specifically Polycom to decrease the costs, because these are the main vendors that we use right now.

And we're also looking at ways to develop our own equipment and that's probably going to be cheaper.

REPRESENTATIVE BOYD: Ultimately you're talking $300 million. It's a substantial investment, which obviously would imply that you guys believe that this is a long-term, viable solution to providing health care and health -- health care for a broader range of patients. Is that a fair statement?

DR. WATSON: Yes.

REPRESENTATIVE BOYD: I mean I wouldn't imagine anybody would be investing $300 million if they didn't think they were going to get some return on that investment in the future.

DR. WATSON: The $300 million is for all the IT infrastructure, but it's going to have the capacity to handle telehealth. We're not -- I want to be clear. We're not investing $300 million specifically for telemedicine, but it's giving us the capacity to do what we need in telemedicine and that's part of the rationale behind doing this.

I'll say, you know, if I had my white coat on now and tell you what, from my personal point of view as a physician, and also, to be honest, having had open heart

surgery and been on the receiving end of what I do, which is pretty miserable, there is -- this is a real need for us. Patients will really benefit.

When you come home after surgery and you feel like hell, the last thing you want to do is have to go back to your physician's office. And if a visiting nurse could come to my house and drop off a device where I could talk to the physician via camera, I wouldn't have to go to the office. They could listen to my lungs, make sure I'm okay. My family didn't have to take time off work.

I mean the ramifications of this are really tremendous.

REPRESENTATIVE BOYD: Okay. And we're here actually -- I mean it's fantastic information and -- and I'm a little bit, and I think other members on the committee, excited about the -- what technology can do for the health care industry.

But really the crux of this and what we're talking about is this House Bill 1849. How do you see this bill as being imperative to the proliferation, if you will, the

expansion of the use of telehealth services?

Is this -- I mean it's a very short bill and ultimately its goal is to mandate insurance coverage for telehealth procedures.

Do you see this as being absolutely essential or is this industry going to explode without this bill?

DR. WATSON: The biggest obstacle to telemedicine now is physicians being reimbursed for this. And it's what Chairman DeLuca said in that physicians want to adopt some of these technologies but at times they need to be educated, but also they need to be reimbursed for this.

If physicians are going to take time out of their schedules, for example, to do a telemedicine clinic, they should be reimbursed for it as long as -- and I agree with what you're saying in terms of the exams should be as good and the people need to be satisfied with the quality of care. You need to deliver high quality care that is as good as you would have done were you in person.

I think the biggest obstacle that we have is having the payers help to develop

methods with us to pay for telemedicine that we can go to a payer, like our health plan, or with the state's Medicare program, and to look at models for telemedicine, such as stroke or wound care, ophthalmology, cardiology, and look -- and we can look together for very good viable models that make sense.

I think to say that absolutely all telemedicine, blanket, should be paid for, in my mind I'd have to think about that some more. But I think very specific beneficial programs that we can look at, and we're starting to see more and more, I think there's going to be a huge array of programs that would -- that should be covered.

But this bill has the ability to remove one of the greatest barriers for telemedicine, which is, if we can provide high quality care that's just as good as if we saw the patient in person, the physician should be reimbursed for that. And that's the barrier.

REPRESENTATIVE BOYD: So if I understand what you're saying correctly, I'm thinking back to years ago, I mean I'm talking 25 years ago probably, maybe even longer, 30

years, my grandfather had a pacemaker put in and he had, believe it or not, a simple system that he hooked into the phone and the Lancaster General Hospital did monitoring of him at that point in time.

So this isn't new technology. It's just advanced. I mean this idea of -- of monitoring from the home has -- has been done for a long time.

But what you're saying is, is that insurance companies are not reimbursing for any of those services at all. So as an example, if there's a telemed conference or telemed consult and normally it would be a follow-up visit to surgery and you do it via telemed, if that person came into your office, that person -- or you would be reimbursed for those services. You're saying today, under current insurance procedures, I'll use that term, because I think they could reimburse, you're saying they don't. Is that a correct statement?

DR. WATSON: No. I'm sorry. I should clarify that, sir.

Some of the services are being paid

for in rural underserved areas. CMS will reimburse -- reimburse for telestroke in rural underserved areas.

But the issue -- like we have hospitals that are not in rural areas or in underserved areas, but they don't have a neurologist.

So if a patient in that area has a stroke and they're not in an underserved and rural area, they go to the emergency room and the neurologist is not available, it's no different than if they were out in the rural, underserved area. And that's one of the barriers that we're really encountering.

REPRESENTATIVE BOYD: Are insurance companies resistant to reimbursing for these procedures at this point in time?

DR. WATSON: We've been talking to our -- our -- our payer, the UPMC health plan, and we actually had some very positive conversations with them.

We're looking at pilot programs which would include, but not limited to, telestroke, wound care, there's some consideration of ophthalmology. They're working on paying for

psychiatry as well for the adolescent program that I described earlier. And I think there's going to be some tremendous inroads and some pilot programs to be developed together.

REPRESENTATIVE BOYD: Thank you, sir.

Thank you, Mr. Chairman.

CHAIRMAN DELUCA: Just -- just to piggyback on the previous question that Representative Boyd asked, you stated that you would send a health care nurse with this equipment, home health care nurse with equipment, and that would be sent back to the doctors then. Is that correct?

DR. WATSON: Correct.

CHAIRMAN DELUCA: Would -- how long does that take? I mean when I say -- I'm not talking how long would that take. How long would that take for the doctor to review that? Because I would imagine he's not going to get rid of his practice. He's going to be seeing patients.

And so what happens? Does he drop that patient load and --

DR. WATSON: The physician --

CHAIRMAN DELUCA: -- then concentrates on the home health care one or how does that work?

DR. WATSON: There's a few models that you can do this. We saw a number of physicians in Texas. One was a cardiologist who gave up his entire clinic-based practice. All he does is telemedicine. He sees about nine to twelve patients a day in a row. It's just like being in clinic, but his office is -- he sits in an office. These folks can be a couple blocks away or a hundred miles away.

For the model that you gave, I would expect it's no different than what I face now. If I see a series of patients in clinic, I see a follow-up patient every 15 to 20 minutes. I see new patients every 45 minutes.

If some data came in, my nurse would review it and say to me, you know, Andrew, this data just came in, you should review this, or at the end of the day she will have screened it as it came in or there will be a -- I'll either screen it real-time or my

nurses will screen it real-time or they'll look at it at the end of the day.

CHAIRMAN DELUCA: So the nurse -- the nurse in your office would screen it first --

DR. WATSON: Correct.

CHAIRMAN DELUCA: -- and give it to you?

DR. WATSON: I think if this information, when this program expands, my view of it is we have a telemedicine center. We have a series of folks in the telemedicine center constantly monitoring the data.

Because if this becomes a large project, there will be data coming in real-time. And with the electronic medical record, you can actually have abnormal values automatically flagged, more severe values put to the head of the queue, so if someone comes in and your blood count is one-third, that gets moved to the top of the list for someone to review versus everybody else where their blood counts are normal.

And with some very simple software, you can actually -- that the person reviewing it will see the most risky ones or the most

important ones up-front.

CHAIRMAN DELUCA: And one final question. Representative Taylor mentioned about this concern of whether we would outsource some of this stuff to other countries.

Is it -- am I under the misconception then that we already do some of that with radiologists?

DR. WATSON: They can do some.

CHAIRMAN DELUCA: Are we already doing that right now?

DR. WATSON: They do what -- they can do what is called a wet read. And I think some of this has been done in India and other countries where they can give you a preliminary read, so to speak.

But in terms of the actual practice of medicine -- I'm not saying that radiology isn't a part of medicine. But I'm saying examining patients and seeing patients and prescribing medicines, which is -- prescribing treatments and medicines, that has to be done by a licensed physician in the state of Pennsylvania.

CHAIRMAN DELUCA: So the radiologists are not licensed in our states?

DR. WATSON: I don't -- I don't know the exact specifics of how this works. I'm not sure that we do this. I mean how that works at a remote site, I couldn't answer that.

CHAIRMAN DELUCA: Okay.

DR. WATSON: But I know in terms of prescribing treatment, you have to be a licensed Pennsylvania physician.

And at UPMC we're actually going to have a 24/7 teleradiology program where our physicians can do this anywhere in the state or in the country.

CHAIRMAN DELUCA: Very good. Any other questions?

Thank you, doctor. Thank you for your testimony. We certainly look forward to talking to you more about this certainly interesting subject. As technology changes we certainly need to change with what we do.

DR. WATSON: But you've seen it first-hand and whatever I can do to help and talk, I'm willing any time to come out here.

It's with a passion, and I love this and enjoy this.

CHAIRMAN DELUCA: Just this thought. Just talking about my first-hand, let me give you an example that I also experienced. I just want to -- we talk about home health care nurses.

I had a home health care nurse come in at first, when I was first sent home, because I had a week in the hospital and therapy.

As we know, we're talking about reducing hospital-acquired infections and I wonder about the infections that we would save with our home health care situation.

To give you an example, she -- she was going to change the wound dressing and she goes into her briefcase to pick out her computer and she goes and washes her hands. Then she comes back, and she's back in her briefcase to the computer there, and then she wants to change -- change the dressing on the wound, which I refused to let her do.

So I'm just wondering, you know, we need to start looking at that. Some of the

home health care nurses are not cleaning their hands.

DR. WATSON: You're exactly right. Handwashing is a major part of what we do.

CHAIRMAN DELUCA: That's a major problem in our hospitals and that there, yet in home health care you wash but yet you go back into your briefcase to pick out your computer because everything is on your computer anymore and then you start changing the wound. Doesn't make sense to me.

Thank you.

DR. WATSON: Thank you all for your time.

CHAIRMAN DELUCA: We do have our sponsor of the bill that just came in.

REPRESENTATIVE COHEN: Go ahead.

CHAIRMAN DELUCA: Okay. Mark Cohen, who is the prime sponsor of the legislation, Mark, do you have a statement you want to make?

REPRESENTATIVE COHEN: Yeah. I'll just be very brief, Mr. Chairman.

CHAIRMAN DELUCA: Sure.

REPRESENTATIVE COHEN: I believe that

this legislation is an important step towards both long-term health care and it enables people to be treated for -- for a disease they may have earlier and more comprehensively than they might otherwise be.

It should -- it should save health care cost in the some instances by limiting the need for travel and by limiting the need to force doctors and other medical personnel to travel.

I believe this is one of many, many things that we can do to improve the access of health care for all Pennsylvanians, and I deeply appreciate, Mr. Chairman, your very prompt scheduling of this hearing to give the advocates of this legislation a chance to make their case.

This is the kind of thing that can get bipartisan agreement and become enacted into law, and I deeply appreciate your very prompt leadership on this matter.

CHAIRMAN DELUCA: You're welcome, Representative. We have a -- I think some of our members want to ask you a couple questions.

Representative Mensch.

REPRESENTATIVE MENSCH: Representative Cohen, I think we would agree that this is in the right direction.

I'd like to get a sense, though, for your thinking in the provision of coverage where you talk about -- actually it's even before that.

But whose responsibility is it for the investment of the initial equipment, the hospital or will the insurance pay for this? Who is going to make that initial investment in the equipment?

We've already talked with -- with Dr. Watson. A lot of it is vetted already and in the development of the infrastructure in the country, but there will be some unique equipment at the hospital end and at the patient end. Who makes those investments?

REPRESENTATIVE COHEN: I believe the standard of practice is for the hospitals to make the investments first and then to be reimbursed. On a per patient basis, depending on the utilization of the services.

REPRESENTATIVE MENSCH: Okay. So the

insurance companies in the end are going to bear that cost? Is that what you're saying?

REPRESENTATIVE COHEN: I think the price of services depends, in part, upon the initial investment and the cost of -- of the -- of the services by the medical providers.

So I assume the insurance companies will bear part of the costs ultimately, and they'll bear a large part of the savings ultimately from -- from quicker treatment and from not paying transportation costs.

I know in my district, for instance, the leading hospital is Albert Einstein Medical Center which is among the preeminent hospitals in Philadelphia in many ways but it's not the preeminent hospital in every way.

And to transfer a patient from Einstein Medical Center to the University of Pennsylvania Medical Center, which is the preeminent hospital in other areas, it -- it is a very expensive task and a very time-consuming task if there's heavy traffic.

So -- so one instance of -- of

somebody not having to physically travel to the University of Pennsylvania Hospital from Einstein Medical Center could easily save thousands of dollars in health care costs, and in rural areas where transportation is even more difficult. Those other costs would be greater.

So I think there would savings and cost effectiveness.

REPRESENTATIVE MENSCH: I would -- I would agree with you on your observation of the cost savings.

My -- my concern would be that the insurance companies end up paying for the initial investment for the hospitals.

Moving on to another question then, under the provision of coverage, in point number three, you say that the use of telehealth will result in lower health care costs than if it were not in use.

Now, this is an identifier that the professional needs to certify. How is the professional going to certify that the procedure is always going to save money? What mechanism do we have to identify or how are we

going to quantify that?

REPRESENTATIVE COHEN: I believe that will be a question based on the judgment of the professional. I'm not sure that it can be inherently quantified.

REPRESENTATIVE MENSCH: But we say that they have to be able to, but we say that they can't?

REPRESENTATIVE COHEN: I think they can't with -- with a hundred percent precision in all cases, I think ultimately -- ultimately this is a belief of a professional based on considerable professional experience.

REPRESENTATIVE MENSCH: Okay. I'm just -- I'm just asking because it's within your bill and it's one of the criteria for the certification for the doctor or the professional to be able to provide the coverage. So I think --

REPRESENTATIVE COHEN: I think this was an attempt to deal with your concerns about costs; but if people would feel more comfortable not having it in there, I think I would be willing to remove it.

But this was just an attempt to limit

costs.

What we're talking about is using the Einstein/University of Pennsylvania analogy, again, if somebody -- if -- if somebody broke his arm, for instance, something that Einstein, you know, is fully capable of dealing with, there would be very little argument you could make in costs for having a specialist from the University of Pennsylvania look at it. It would be a very good question, but if the delay being seen crucial, you know, of course, if you get there 45 minutes late and there's rush hour traffic, there's very little that could be changed.

But if it was some rare disease that the University of Pennsylvania specialized in, where the doctor's opinion -- every -- every minute was of vital significance on the thing, then there would be savings.

That's all it seeks to do.

REPRESENTATIVE MENSCH: I think conceptually you and I agree so maybe we can continue this conversation on this offline.

Thank you, Mr. Chairman.

CHAIRMAN DELUCA: Thank you.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

CHAIRMAN DELUCA: Thank you.

The next individual to testify is Kathleen Fitzgerald, the executive director of the North Penn Visiting Nurse Association and the Pennsylvania Homecare Association.

Welcome.

MS. FITZGERALD: Good morning. My name is Kitty Fitzgerald. I'm the executive director of the North Penn Visiting Nurse Association in Lansdale, Montgomery County. I'm here representing my organization.

And I am also here representing the Pennsylvania Homecare Association. And for the record, I would like to say I am a home care nurse for the last 35 years.

CHAIRMAN DELUCA: Very good.

MS. FITZGERALD: Thank you. I also thank you for this opportunity to talk with you about telehealth, particularly its use in patients' homes across Pennsylvania. In fact, Pennsylvania's home health industry is a leader in telehealth use and, according to a study conducted by the University of

Pittsburgh, more than 7,000 units are being used today by home health agencies.

This significant number is the result of three congressional appropriations that were awarded to the Pennsylvania Homecare Association totaling $800,000 that provided agencies with seed money to purchase telehealth equipment.

But before I go any further, I think it's important to define what I mean by telehealth. Telehealth or telecare is the remote monitoring of patients' vital signs and activities. About 30 percent of home health agencies utilize some form of telehealth or in-home technology, which includes vital signs monitoring, automated medications monitoring, activity sensors, and certainly emergency response systems. Our agency currently uses remote vital signs monitoring.

Remote vital signs monitoring is especially beneficial to patients with chronic conditions such as congestive heart failure. According to the American Heart Association, nearly 5.3 million Americans have heart failure and more than 287,000 people die each

year with heart failure.

Heart failure is also the most common diagnosis of Medicare patients and more Medicare dollars, 2.4 billion, are spent on the diagnosis and treatment of heart failure than any other diagnosis. It is the primary reason for an estimated 6.5 million hospital days annually.

In 2005, the total estimated cost for treating heart failure was 27.9 billion and increasing to nearly 29.6 billion the following year.

With this in mind the North Penn Visiting Nurse Association initiated a heart failure/telehealth program to manage patients with this chronic disease in their own homes. Our program is called TLC, telehealth learning control.

The objectives of this program are to:

Detect signs of impending decompensation and provide appropriate intervention.

Reduce the number of unnecessary visits to the emergency department and costly

readmission to the hospital.

Improve the quality of life for patients by promoting self-management.

Improve compliance through education and increased understanding of disease process.

And, lastly, promote communication between patient, physician and clinician.

Our agency began its program in June 2006 when we were asked to participate in a national study looking at the effectiveness of telehealth and nursing utilization.

In December of that same year, at the completion of the study, we made the decision to lease 30 monitors and six months later we leased an additional 30 monitors. Over the life of the lease, our organization will spend close to $220,000 just for the equipment.

Since there is no reimbursement for telehealth services, the cost has been absorbed by the organization because we believe that our home health patients with heart failure would ultimately benefit from care management that included telehealth monitoring.

Below are summaries of three research projects which demonstrate the cost savings benefit of using telehealth equipment in caring for the supporting -- and supporting clients with chronic illness in their homes.

The first study that I'm going to reference is the Pennsylvania State University cost analysis of telehome care.

A total of 171 diabetic patients in Philadelphia were included in this study. 86 patients received video telehealth visits in addition to traditional home care by a nurse. The other 85 patients received traditional home care but no telehealth equipment.

I would like to direct your attention to the difference between the two groups with regard to -- with regard to the percentage requiring hospitalization and then the associated estimated costs of those hospitalizations.

The second study is the telehome care outcomes study. Strategic health care programs compared outcomes between patients that received telehealth with other home care services and patients that received

traditional home care services but, again, no telehealth equipment.

Data utilized for this study came from 41 states and was taken from millions of CMS-mandated assessments transmitted from 178 home health agencies utilizing telehealth monitors and more than 300 agencies that did not use telehealth equipment.

The study is the cumulative result of 27 months of experience dating from January 1st, 2002 through March 31st, 2004. And, again, I direct your attention to the figures as they relate to hospitalization rates and emergent care visit rates.

The third and final study that I'd like to reference is the Kaiser-Permanente telehome care research project.

This research project studied 102 patients who received telehealth in addition to routine home health care and 110 patients as the control group who received routine home health care but, again, no telehealth equipment.

Patients had congestive heart failure, chronic obstructive pulmonary

disease, cerebral vascular accident, cancer, diabetes, anxiety, or need for wound care.

The total cost per patient, including outpatient costs for physician and emergency room visits, laboratory and pharmacy tests and hospitalizations costs, were $1,948 per patient having telehealth and in-home visits and $2,674 for patients receiving just home health care and no telehealth equipment.

The study also found no difference in quality indicators and patient satisfaction between the control group and the telehealth group.

The question that begs to be asked is why, despite valid research that supports the use of telehealth by home health agencies in caring for chronically ill patients, is there no reimbursement by insurers, including Medicare and Medicaid?

And as a follow-up question, will the indifference on the part of insurers stifle technology's use because in the end telehealth monitoring has demonstrated that it can save insurers thousands of dollars by reducing costly hospitalizations and emergency room

use.

You might be prompted to ask me why then are home health agencies, like the North Penn Visiting Nurse Association leasing, or in the case of some of my peers, purchasing the equipment when there is no reimbursement?

The answer is in the reimburse -- reimbursement methodology. Under traditional Medicare, home health agencies are reimbursed under a prospective payment system which is based upon a 60-day episode of care.

In other words, we receive one bundled payment which is calculated on a number of factors, such as the seriousness of the illness and the functional capabilities of the patient.

In a 60-day episode of care, an agency can reduce nursing visits but continue to monitor the patient closely, the patient recovers and stays out of the hospital, thus enriching the care of the patient and efficiently utilizing the resources of the agency.

This was the basis of the original research study in which we participated.

Telehealth is the key that enables -- enables agencies to do this. In fact, by implementing a remote vital signs monitoring, one or more nursing visits per week can be eliminated. The average cost of a nursing visit is approximately $100.

Other insurances, such as managed care Medicare and Medicaid can reimburse home health agencies by the visit. Therefore, the use of telehealth is a disincentive, but for as little as $10 a day a patient who has managed care Medicare or Medicaid can be evaluated remotely by a nurse, receive quick response to an impending medical emergency, avoid an unnecessary visit to an emergency room or hospitalization.

This is a win/win situation for everyone. Patients experience improved health outcomes and remain out of the hospital. Insurers end up saving money in the end due to reduced rehospitalization rates and lower emergency room utilizations, and home health agencies can efficiently utilize their resources while continuing to provide the best care to their patients.

Unless all payer sources recognize the cost effectiveness of providing in-home health care that includes the use of telehealth, thousands of chronically ill patients will not have the full advantage of a care management tool that has proven to improve patient outcomes.

House Bill 1849 provides for reimbursement of telehealth services by all Commonwealth insurers. Passage of this legislation would be a significant step forward for Pennsylvania and is in concert with the Governor's Prescription for Pennsylvania.

It would also support and promote chronic care management which has proven to be effective in controlling rising hospitalization rate costs.

I think we are all in agreement that technology must play a more significant role in health care, not just the delivery of the care but in managing health care costs and utilizing scarce resources more efficiently.

As budgets continue to bulge with growing health care costs, government must

look at ways to reduce costly care, with an emphasis on prevention.

Home health care has a long-standing proven history in being proactive in educating and engaging patients in disease management. The added value of telehealth further enhances that relationship for the consumer by engaging them in the day-to-day monitoring of their health care, allowing them to easily manage their illness more effectively.

Finally, I have provided you with two scenarios describing home patients using telehealth and how this one tool has dramatically affected their lives.

I would be happy now to answer any questions that you might have, and I thank you for this opportunity to being here this morning.

CHAIRMAN DELUCA: Well, thank you, Kathleen. I guess one of the questions you asked was the fact that this could be a savings. You wonder why the insurance companies would not want to reimburse for this.

And I would think, as I look at some

of your examples here, the savings you cite on a couple of these examples, I'm sure the insurance carriers, your results on number one, 87,327 compared to no telehealth care $232,872, is really a substantial amount of revenue.

So why would you believe the insurance companies who certainly have cut cost in other avenues in health care would not want to go to telehealth and reduce their costs to -- for their -- their companies?

MS. FITZGERALD: You know --

CHAIRMAN DELUCA: It's just -- it's such a prevalent thing.

MS. FITZGERALD: It sounds like such a simple answer, doesn't it?

CHAIRMAN DELUCA: Yes, it sounds very simple, but I guess it can't be that simple because --

MS. FITZGERALD: It isn't.

CHAIRMAN DELUCA: -- the insurance companies are certainly looking for ways that -- you know, as a visiting nurse, they're cutting back on a lot of things what they -- what they pay for, the copayments, and the

fact that some of the procedures where they save, they're not necessary.

So I mean why would they not be interested in such a thing? You're one example here. I imagine if you do that throughout the Commonwealth, that's pretty substantial money for insureds.

MS. FITZGERALD: That's correct.

CHAIRMAN DELUCA: Why would they not be in favor of reimbursement? Tell me.

MS. FITZGERALD: I would have to give an opinion on this.

CHAIRMAN DELUCA: That would be okay.

MS. FITZGERALD: My opinion is because they don't do it and why introduce another cost that they haven't already paid for.

CHAIRMAN DELUCA: Could it be that they don't -- could it be the fact that there really is no substantial evidence that it has reduced that --

MS. FITZGERALD: But there is substantial --

CHAIRMAN DELUCA: -- cost where it is

going to save money?

MS. FITZGERALD: I believe there is substantial.

CHAIRMAN DELUCA: You believe there is?

MS. FITZGERALD: There is.

CHAIRMAN DELUCA: Okay. Very good.

Any other questions?

Representative.

REPRESENTATIVE NICKOL: Thank you. You indicated that you're typically -- provide 60 days of episode care or something, that you're pre-approved for some certain period of time for -- during which you'll provide the home care.

MS. FITZGERALD: Correct.

REPRESENTATIVE NICKOL: Do you -- I'm curious, you know, following up on the chairman's question about insurance companies, does North Penn VNA charge an insurance company less if they allow you to employ telemedicine and reduce the number of professional nursing visits during that 60 days or are your charges the same?

MS. FITZGERALD: Well, let me -- let

me -- there's a difference between the two insurers that you just referenced. The 60-day episode of care pertains to a traditional Medicare encounter. Okay. That's a Medicare reimbursement.

So Medicare provides to the home care agency a dollar amount for us to take care of that patient regardless of how many visits that we have to make or what services we provide or what equipment we bring in.

If we are able to reduce the number of nursing visits, yet still provide the same outcome, that is, the patient is discharged to home, goals met, independent and living, Medicare does pay us the same amount.

A traditional fee-for-service insurer pays by the visit. They're not charged any more or any less. They only pay for what we provide.

REPRESENTATIVE NICKOL: So -- so the companies that we can regulate --

MS. FITZGERALD: Correct.

REPRESENTATIVE NICKOL: -- would be fee-for-service?

MS. FITZGERALD: That's correct.

REPRESENTATIVE NICKOL: And so you would charge them -- I'm gathering from what you're saying, if you're employing telemedicine, they would actually benefit because they wouldn't have to pay for as many skilled nursing care visits.

MS. FITZGERALD: That's correct.

REPRESENTATIVE NICKOL: Or nursing visits.

MS. FITZGERALD: That's correct.

REPRESENTATIVE NICKOL: Okay. Thank you.

CHAIRMAN DELUCA: Representative Cohen.

REPRESENTATIVE COHEN: Thank you, Mr. Chairman.

Could part of the fear of insurance companies be fears of increased utilization and increased costs of -- of operations as a result of people using telemedicine more than they would use a conventional office visit?

MS. FITZGERALD: I don't think that would be the fear. I mean there won't be increased utilization.

The technology potentially can be

increased and the benefit to the patients will be increased. But you will not see an increased utilization of nursing visits. In fact, it will be the reverse of that.

REPRESENTATIVE COHEN: Thank you very much.

CHAIRMAN DELUCA: Representative Mensch.

REPRESENTATIVE MENSCH: Just help me collect my thought.

MS. FITZGERALD: Okay.

REPRESENTATIVE MENSCH: Your association, is it for-profit or not-for-profit?

MS. FITZGERALD: Not-for-profit.

REPRESENTATIVE MENSCH: That's all I needed to know. Thank you.

CHAIRMAN DELUCA: Representative Godshall.

REPRESENTATIVE GODSHALL: I just wanted to say that I want to thank Ms. Fitzgerald for coming up here today. They operate out of Hatfield Township.

MS. FITZGERALD: That's correct.

REPRESENTATIVE GODSHALL: Which is

the heart of my district, where my office is located.

And recently I had a hip replacement this past fall done, and I had a choice of going to a rehabilitation center for a week or two or coming home and using the benefits of the services of the Visiting Nurses Association and -- which I did for approximately a week or so.

And I don't know what the savings in dollars would have been, but it would be astronomical in spending that time in a rehab center.

So I just want to, again, commend the North Penn Visiting Nurses Association. They've done a great job in our area and they're recognized for the great job they do and I -- all I can say is thank you and welcome to Harrisburg.

MS. FITZGERALD: Thank you for your very kind words.

CHAIRMAN DELUCA: That's pretty good for coming from Representative Godshall.

REPRESENTATIVE GODSHALL: I'm usually on the other side.

CHAIRMAN DELUCA: Yeah. You're normally on the other side. So I'm always trying to save you.

Thank you.

MS. FITZGERALD: Thank you.

CHAIRMAN DELUCA: Thank you very much --

MS. FITZGERALD: Thank you.

CHAIRMAN DELUCA: -- for taking the time to come out.

MS. FITZGERALD: Thank you very much.

CHAIRMAN DELUCA: The next individual who will be testifying is Larry Light. He's with the Pennsylvania Medical Society.

Larry, welcome. Whenever you're ready, Larry.

MR. LIGHT: Okay. Thank you. Good morning, Mr. Chairman. I'm here. Roger Mecum, our executive vice president, was slated to be here and could not attend and normally -- Dr. London, our president, was scheduled for surgery today. So I'm here in their stead.

As the -- your committee staff

suggested, I'm going to dispense with the reading of testimony and just make a couple comments.

CHAIRMAN DELUCA: Sure.

MR. LIGHT: I want to thank you for holding the hearing, Chairman DeLuca. I want to thank Representative Cohen for introducing the bill.

This is legislation that the Pennsylvania Medical Society supports. We agree it will result in lower health care costs.

We have -- in our testimony, the one thing we try to highlight, though, is the need to probably expand the bill a little bit more, and it was along the lines of an issue that Representative Mensch brought up, and that is when you have a situation where the telehealth or telemedicine is being provided by someone from out of state.

We've been working on legislation like this, mostly in the Senate, for the last couple of sessions. Haven't been as successful with it as we would like. But we're going to persevere.

And the -- the trend we were following was to require that when the patient is in Pennsylvania that the health care provider be licensed in Pennsylvania.

So if you -- if the -- a lot of this would apply to teleradiology. So if it's farmed out to -- say, those services are being performed by a firm of people, say, in Colorado or another state or even another country, that whoever they're using online, if you will, or through telemedicine or telehealth to provide the services, look at the radiological scans, whatever, that they would -- if a patient is in Pennsylvania and they're providing services to hospitals in Pennsylvania, they're going to have people providing that service who are licensed in Pennsylvania also.

And the key thing about this would be, even go back down to the basics of -- if there's a liability issue, there's somebody who has equal coverage as a Pennsylvania licensed physician. So the patient, if there's a problem, they have somewhere to go. If there's a bad situation.

So that would be the one thing we would suggest that we would definitely want to look at in the legislation.

And I appreciate your earlier question about who is going to make the determination about lowering health care costs. That's not something physicians are necessarily equipped to do and I think that's something we'll have to -- we can work through and figure out a way to handle this.

CHAIRMAN DELUCA: Thank you, Larry. Let me ask you, as the doctor testified, he said you'd have to be licensed in Pennsylvania.

So what -- are you talking about support -- for the support services for the physician?

If the doctor has to be licensed in Pennsylvania, how could they farm that to another state?

MR. LIGHT: They don't have to be in Pennsylvania. They just have to have a Pennsylvania license. There are people all over the country who have Pennsylvania licenses but who aren't actually practicing in

Pennsylvania.

CHAIRMAN DELUCA: Okay. So they could have a license --

MR. LIGHT: Yeah.

CHAIRMAN DELUCA: -- and not practice in Pennsylvania? Is that what you're saying?

MR. LIGHT: Right. But if the patient -- we believe if the patient's in Pennsylvania --

CHAIRMAN DELUCA: Physician should be certified. I understand.

MR. LIGHT: Yeah. When we did -- when we worked on the bill in the Senate, we did have an exemption for -- I think we call it episodic consultation. In other words, the scenario would be something like a specialist, or any physician, it doesn't have to be a particular specialty, wants somebody else to take a look at a case and they call somebody at a -- probably a teaching institution, maybe someone they've worked with before, someone they trained under, and say, here, would you take a look at this? And you send the material out through telemedicine or that kind of a means of transmitting the data and you

get a consult, if you will, from that person.

If they're not being compensated for it, we didn't -- we understood that they wouldn't have to be licensed in Pennsylvania. But I mean -- now, if they're doing a series of them and they're looking -- and there's -- and there's compensation involved, then if the patient is in Pennsylvania at a Pennsylvania hospital or -- or in Pennsylvania, then they should be licensed in PA.

CHAIRMAN DELUCA: And I agree.

Is there any questions for Mr. Light?

Representative.

REPRESENTATIVE NICKOL: Just as a follow-up to your comment you just made, Pennsylvania, one of our premier assets are institutions like UPMC and other national renowned medical centers.

If we were looking at economic development and the building of a business model based on telemed services, it would seem like we'd be a national center.

Would the requirement that -- that we might place on telemed services and

reimbursement for those in Pennsylvania, that someone has to be licensed in Pennsylvania, would that not be adopted by other states then and prove a barrier to us providing services from these nationally renowned medical centers in Pennsylvania to patients in other states?

MR. LIGHT: I suppose that's possible. It's something we'd have to try to work through. But I think that could become an issue down the road.

REPRESENTATIVE NICKOL: Thank you.

CHAIRMAN DELUCA: Representative Mensch.

REPRESENTATIVE MENSCH: Yeah. Larry, let me follow up with that train of thought.

How -- when I'm a doctor in Pennsylvania and -- and -- no. Let me rephrase it.

I'm a patient in Pennsylvania and somehow I talk to somebody in Ohio and have a telemed consultancy, how do I know that -- they're in Ohio, with the ability of the Internet, when I get -- when I get -- say they prescribe something for me. How do I know? What catching mechanisms are there to -- I

mean there's no stamp on the call.

MR. LIGHT: Yeah.

REPRESENTATIVE MENSCH: They don't really know where it originated or where it terminated.

MR. LIGHT: Well, I don't know. I'm not quite sure why that would -- how that circumstance would come about.

REPRESENTATIVE MENSCH: I'm not sure either.

MR. LIGHT: You know.

REPRESENTATIVE MENSCH: But we were talking earlier, you know, about consultants in -- in India or other countries or other states. I'm wondering if and when that actually happens, how do we catch it?

MR. LIGHT: My understanding of what we're trying to deal with with the Pennsylvania licensure is a situation where somebody would actually contract with a -- with a practice or a firm that provides those services and that they are domiciled out of the state.

And we're trying to look at those situations where they're going to be a lot of

work.

Now, if you're just a patient and you're contacting somebody from out of state on your own behalf, then that, I think, would come under the episodic consultation kind of thing.

REPRESENTATIVE MENSCH: All right. Thank you.

MR. LIGHT: There's a lot to be worked through here.

REPRESENTATIVE MENSCH: Yeah. I see that. Thank you.

CHAIRMAN DELUCA: Any other questions for Mr. Light?

Representative Cohen.

REPRESENTATIVE COHEN: Mr. Chairman, I would just like to thank the Pennsylvania Medical Society for their support of this legislation.

And I agree with you conceptually and I look forward to working with you in whatever calls there might be.

MR. LIGHT: And we look forward to working with you, Mr. Chairman and Mr. Cohen.

CHAIRMAN DELUCA: Larry, let me just

ask you one question. Since you said the Pennsylvania Medical Society is in favor of this, what is the position of AMA on this telemedicine?

MR. LIGHT: I'd have to get back to you on that. I don't --

CHAIRMAN DELUCA: Could you get back to me?

MR. LIGHT: Yeah. I'm not sure if they've looked at it.

CHAIRMAN DELUCA: There are states that have it?

MR. LIGHT: Yeah.

CHAIRMAN DELUCA: I certainly would appreciate you finding that out.

MR. LIGHT: We'll certainly check their policy.

CHAIRMAN DELUCA: Okay. Thank you.

The next individual testifying is Joseph Tracy. He's the vice president of the Lehigh Valley Hospital.

Welcome, Joe.

MR. TRACY: Well, thank you.

CHAIRMAN DELUCA: Thanks for taking the time to come here and testify on behalf of

this piece of legislation. It's innovative. And I guess it's a piece of legislation you support?

MR. TRACY: Yes. We appreciate being here, Chairman DeLuca and Representative Cohen and the committee. It's a great opportunity.

Just a little bit of background on myself. I'm Joe Tracy, the vice president for Telehealth Services for the Lehigh Valley Hospital and Health Network in Allentown. I have some side jobs. I'm also chair for the Center for Telehealth and eHealth Law in Washington, D.C.; a member of the Health Information Management Systems Society's Advocacy and Public Policy Steering Committee. I'm also on the policy committee of the American Telemedicine Association.

Lots of great questions. So if I could just depart from my testimony, which I have written, and try to address some of the other questions that have been raised.

There's actually a sixth state now that has legislated telehealth reimbursement, and that would be Georgia.

I've also included in my testimony a

table from the Telemedicine Information Exchange that shows commercial insurance carriers that were paying for telehealth in the 50 states, and that's as recent as 2005.

In terms of the outsourcing issue on radiology, one of the more prominent groups in that area is NightHawk Radiology. Last I heard from them, they spend about $65,000 per physician, licensing them in all 50 states and having them privileged and credentialed in the hospitals where they provide service.

So they're trying to do the right thing, even though that, you know, these are typically American-trained physicians. They just happen to be residing in places like India and Australia.

In terms of your point on infection control, a good point. You know, the new mandates to report hospital-acquired infections here in the state, there is a limited number of infection control specialists in the state. You know, they're just not everywhere. And using these telehealth technologies, as Dr. Watson and the others have described, we can make them a

little bit more available for not only helping hospitals and patients but also for the education component in teaching their infection control teams a little bit more in terms of helping on that issue.

In terms of Number 3 in the bill, there is Section 7202. I have in my testimony on -- my written testimony on Page 5, I've kind of requested that Number 3 be removed and replaced in terms of adding an evaluation committee, because I don't think, as you heard from the others, that any -- any one individual physician will be able to give you the full costs savings on any given patient because they won't know the history.

And -- and I guess in reality the commercial insurance carriers would know how often that patient may have been treated for a condition before they were turned over to a specialist.

So I think the commercial insurance carriers would have that very data which you seek. But I'd rather have an independent evaluation team take a look at that.

In terms of other licensure issues,

my last count, there was about 36 states in the United States that had licensure laws that require full licensure in a state if you were going to treat a patient in that state.

So in terms of the other comment, I mean it's just out there and it's -- it's in a lot of state laws. There are a few that have a limited license for telehealth where you can provide a few consultations.

I got to tell you, I have one of the greatest jobs in the world because I get to provide technologies that provide access to people that don't generally have access to health care services. So it's really good.

Some examples from Lehigh Valley Hospital, to add on to Dr. Watson's, when we use interactive real-time video, one of the most powerful applications that we're working on and that has been used in other states, is to be able to use this technology to care for high-risk pregnancies.

Women in that condition don't travel well. It's kind of -- it's sometimes kind of dangerous for them to travel, and we would rather have healthy babies than babies that

wind up in the neonatal intensive care unit.

And we talk about costs. A couple years ago when I took a look at this for Lehigh Valley, the cost of a baby, on average, winding up in the neonatal intensive care unit was 20 times that of the cost of a normal newborn.

We can use interactive video to see ultrasounds in real-time. We can install forward technology to see the still images of those ultrasounds and using this technology the physicians can communicate in real-time with the ultrastenographer's patients' nurses in the remote areas.

We also have at Lehigh Valley an advanced ICU, which having been around the country over the last 15 years looking at various telehealth sites, I got to say it's probably one of the most powerful telehealth applications in combination with health information technology that I've ever seen.

And I would invite the committee to come and see us, take a look at this, along with the other telehealth applications because sometimes it takes a visual -- sometimes it

takes you sitting in front of the system to just see the power of the technology and what it can do for the patients throughout the Commonwealth.

And in terms of reimbursement, I got interested in the reimbursement policy back in 1997 with the Balanced Budget Act at the federal level, which had some unworkable language in terms of telehealth reimbursement.

So I was fortunate enough to draft the language for the Southern Governors Association and Senator Jim Jeffords on Senate Bill 2505, most of which was signed into law in 2000 as part of the Benefit Improvement Protection Act. And it's kind of the Medicare reimbursement that we enjoy today.

Also after joining Lehigh Valley Hospital, I'm proud to say that our insurance product, our own insurance plan, does pay for telehealth services.

It would be difficult for me to sit here and look at you and look at the commercial insurance carriers and say, please, pay for that -- pay for this if my own plan

doesn't. So I'm happy to report that we do pay for telehealth consults.

In terms of payer concerns over this, you know, some of them -- a lot of them you've mentioned and I think they're unfounded.

There is a concern that increased access equals increased costs. I'm not sure that's quite true. HCFA, back in the early '90s, now CMS, thought that way early on and they were telling the Congressional Budget Office that telehealth would cost billions on the nation's health care system. However, they had no data to back that up.

Working with some others across the country, we compiled a grass roots study of utilization of telehealth and that study was used as the Congressional Budget Office basis for scoring Senator Jeffords' bill at only 150 million over five years. So significantly less than a billion.

Six years has expired since that bill was scored, so we're beyond that five-year period, and Medicare has only spent $4.2 million in terms of telehealth reimbursement or only three percent of CBO's estimate. So

in terms of HCFA and CMS's concerns that the budget would be blown over this, that did not prove to be the case.

I've also received several letters recently from commercial insurance carriers here in Pennsylvania that basically cite that there's no scientific evidence that telehealth equals that of in-person care.

And I -- I have a problem with that. One is scientific evidence and randomized control trials are difficult to do in a environment like this in the real world.

We're not testing a drug over many years with many different trials. We're using a communication tool basically to enhance access and provide communication channels for physicians and other providers.

And in a randomized control study you usually have an intervention group and control group. I don't think there's a single physician that would withhold a communication service that might save the life of the patient simply because the patient is in a control group.

So I wrestle with the fact they're

looking for this scientific evidence at that level.

There's also inconsistencies in the insurance companies across the country. You will see in that chart in my written testimony that there are many of these insurance companies that are paying in other states, even the ones that aren't legislated; yet they're not paying here in Pennsylvania.

So are we so much different here in Pennsylvania that we are -- we need to be a scientific study versus the other states?

I think telehealth treats patients the same way regardless of where they live.

We're also in a Catch 22 in terms of evaluation and research. One of the barriers, as you heard, to doing, providing the services is reimbursement.

If physicians and other providers aren't paid for what they do, they typically don't do it. Unfortunately, if they don't provide the service in this matter, we have nothing to evaluate.

So the reimbursement mechanism under this bill is vitally important so that we can

begin to gather the data that we need.

Other reasons to pay, Aetna and Cigna are both publicizing the fact that they're going to begin reimbursing for e-visits using a product called Relay Health. E-visits can equate to a video camera on your computer. It could also equate to simple e-mail between you and your physician.

The Department of Public Welfare here in Pennsylvania has also stepped up, and they are reimbursing for maternal fetal medicine services, as well as for the management of psychotropic medications by psychiatrists.

I was also privileged to be on the advisory committee for the Center for Information Technology Leadership report that Dr. Watson mentioned.

It -- it does indeed show how we can save a lot of money by using these technologies across the country. And one of the major powerful applications of this is just being able to use our scarce resources and spread them out a little bit across -- without having physicians travel. And by that, I mean right now there are currently

6,000 board certified intensive care physicians, intensivists in this country. We need 15,000.

There's -- there's really simply no other way sometimes than to use this type of technology to provide their expertise in places where it doesn't exist.

So I really like the bill. I really appreciate being here today. My testimony, my written testimony, does have a few recommendations for changes. Because I want to ensure that the telehealth encounters and consultations are paid at the same rate as an in-person visit.

And I would also suggest that we require all the physicians just to simply document their cases with a GT modifier in front of the billing code, in front of the CPT code. That would be an indication that this -- the encounter was done by telehealth, and it would also be an easy way for insurance companies to go back and extract the data by looking only for the GT codes. So it does -- it will help the evaluation process.

In summary, you know, telehealth is

just a tool to provide care at a distance. It provides the right care, at the right time, at the right place, and at the right cost.

And, frankly, an individual's address here in Pennsylvania should not dictate where they can get health care. We should have this -- this bill will take care of that.

Again, I invite you to come to see us at Lehigh Valley Hospital. I think a visual and a demonstration would be very helpful for the committee.

I can't thank you enough for doing this, and I'd be happy to answer any questions you have.

CHAIRMAN DELUCA: Thank you, Joe. And I guess I looked over some of your testimony and I see a lot of states are reimbursing for the Medicaid part of the telehealth. Yet some of the private payers is not.

Why would you -- I mean they certainly would have -- if they're reimbursing for Medicaid, they're probably seeing a savings, a cost savings in the Medicaid program.

Why would not the insurers take that -- that situation where it's documented that they're saving costs, they start covering that, I see a -- most of it is all Medicaid, there's a few of these are private payers, but I see most of the Medicaid programs are doing it in a lot of these states, but the private payers are not doing it.

MR. TRACY: That's correct.

CHAIRMAN DELUCA: So I mean why do you believe the insurance carriers couldn't take that data from the Medicaid program, the cost savings, and move it to their own insurance companies and see the cost savings?

I mean it has to be a cost savings in the Medicaid programs.

MR. TRACY: Yeah. Unfortunately, we go back to the early '90s. Most of the telehealth programs were federally funded projects aimed at very, very rural areas.

As a result you're treating a very underserved population of patients with a high preponderance of Medicaid coverage, and I think a lot of state representatives who cover -- you know, have constituents in those

areas are -- you know, the major universities that have these programs and other places that have telehealth programs have gone to them with their data and somehow convinced each -- each Medicaid program to do -- to provide some reimbursement.

And I'll tell you. I don't think they're all the same. DPW here and the Medical Assistance program is going to pay for maternal fetal medicine and the psychiatrist for managing psychotropic medication, but beyond that, those are just going to be a carve-out for now until we can open it up for home care and other specialties.

So, you know, it's -- when you look at the map, the Medicaid programs all treat this a little bit differently. And I wish I had an answer.

CHAIRMAN DELUCA: Could it be because of the fact that a lot of doctors don't participate in the Medicaid program and they need another way of taking care of the Medicaid population and the poor population?

MR. TRACY: Yeah. You know, coming from the University of Missouri, which was a

safety net facility, you know, the preponderance of Medicaid cases coming into the university system like that was much higher than -- than anything else.

CHAIRMAN DELUCA: Thank you, Joe.

Any other questions? Representative Mensch.

REPRESENTATIVE MENSCH: Can you differentiate for us e-visits from telemedicine?

MR. TRACY: I can in the context of Relay Health because I use that myself. Relay Health is kind of a -- a tool where if I'm really in a non-urgent situation, I'm -- I'm not feeling well, but, you know, I just want a -- I hurt my elbow, I hurt my arm, I want to kind of get a feel for what to do next, I can drop a message into the Relay Health product and it will go to my primary care physician where he'll pick it up, review it, and get back with me.

It's not suggested to be used, of course, for urgent cases. And so -- but I believe also Relay Health does have a video component where, if it were possible, I could

have a webcam, my physician could have a webcam, and we could actually see each other and have a conversation.

There are products like that popping up, and they'll become more prevalent as we move down the road.

But in terms of an e-visit, it's in this case almost like an e-mail in a little bit more secure environment.

REPRESENTATIVE MENSCH: Is there any prescribing of medications or -- in an e-visit?

MR. TRACY: In an e-visit? I have personally not done that. However, I think you can correspond to have your current prescription renewed. Because using Relay Health, you are actually responding with your primary care provider that -- that knows you.

Now, there -- the AMA has approved two new codes for providers and physicians where they will allow reimbursement for those types of visits, e-visits. However, it's up to the insurance companies whether or not to actually pay for those.

REPRESENTATIVE MENSCH: Thank you

very much.

CHAIRMAN DELUCA: Representative Boyd.

REPRESENTATIVE BOYD: Thank you, Mr. Chairman.

I want to go back to something you said in your testimony about -- I believe you said was the Jeffries -- Jeffords' legislation, the federal legislation.

You quoted some statistics that were -- that were just incredible about what they perceived the cost of -- can you go back to that and say that again?

I don't want to let that slip by. That was huge.

MR. TRACY: Okay. I was fortunate enough to be in the right place at the right time. One of my medical directors at the University of Missouri was on Senator Jeffords' majority health staff on the labor -- not labor -- HHS -- Health Education Labor Pensions Committee. So she helped with this legislation, being at his right hand.

We put together a -- a bill written pretty much by the grass roots and gave that

to Dr. Edison who also worked -- what we wrote and what it looked like when it came back was two different things.

But it was then turned over to the Congressional Budget Office and the Congressional Budget Office picked up the phone and called me one day and said, we've got a copy of your report. Can you explain it?

Because HCFA then was telling us this was going to cost, you know, a billion dollars or more if we opened the floodgates to access.

REPRESENTATIVE BOYD: Can I just stop you? So what you're saying is HCFA was saying if, in fact, we would open up to this e-medicine -- is that the right terminology?

MR. TRACY: Or telemedicine.

REPRESENTATIVE BOYD: Telemedicine. That the cost borne by who would be billions of dollars?

MR. TRACY: By the Medicare trust.

REPRESENTATIVE BOYD: Okay. Very good.

MR. TRACY: At that point they -- they took our study that we did -- because I

asked the man, has HCFA been able to give you any data? And they said, no, we don't have any. And I said, I've just given you 5,000 cases from across the country, and you can see how this works and what it's going to mean, and I think you can figure out that it's not going to cost billions of dollars.

So when they scored the bill or priced it, it came back with a five-year $150 million price tag, which, I guess, in Washington doesn't amount to a whole lot.

REPRESENTATIVE BOYD: Okay. And then you said that subsequent to that that there was actual statistics that measured it and it even came in less than the $150 million that they projected it to be?

MR. TRACY: Yeah. Let me just look at the chart real quick. Because I think cite -- we got the -- the Center for Telemedicine and eHealth law got the data from -- from CMS themselves.

We had -- we had a few legislators request it. And it came from the CMS Office of Legislation via the Center for Telehealth and eHealth Law that showed they had only

spent $4.2 million of the $150 million estimate.

REPRESENTATIVE BOYD: Over how long a period of time?

MR. TRACY: That was over a six -- about a six-year period.

REPRESENTATIVE BOYD: So just to make it clear, what they projected the cost, billions, after you supplied data, they revised the projection to cost 150 million, over a six-year period of time cost how much?

MR. TRACY: 4.2 million.

REPRESENTATIVE BOYD: 4.2 million with that?

MR. TRACY: Right.

REPRESENTATIVE BOYD: Mr. Chairman, we need -- we need to implement this now. I mean -- I mean that's -- that -- that's just phenomenal to have something like that, those statistics.

And the reason is because? Why? What do you attribute that to?

MR. TRACY: Well, I think telehealth is mainly just a substitute for your in-person -- your in-person visit. Obviously

when you look at this data, people aren't leaving their -- you know, they're not leaving their homes, but just when you've now opened up reimbursement for physicians at the Medicare level, they didn't exactly just climb on board and say now I'm going to do a telemedicine practice because I can bill Medicare and I never have to leave my PC and never have to see patients.

It doesn't work like that. You know, you -- the providers -- especially on a specialist level, when most of the specialists, you know, are in urban areas, they already have a very, very busy practice.

So by -- by granting -- by putting telehealth out there and granting access, which all you're doing is granting access to their existing schedule. You're not -- they're not adding additional time just to see telehealth patients, but now they're fitting that patient in from -- from Bradford, Missouri or some other -- Missouri -- Pennsylvania into their existing schedule.

And as a result, you know, you're really not opening up a brand new schedule for

people just to use telehealth.

REPRESENTATIVE BOYD: If -- if I understand what you just went through from a statistical cost standpoint, I guess I'm curious.

I would think that insurance companies would be almost clamoring to mandate in their provider -- their network, their provider agreements, that where possible the providers would offer, you know, telehealth to reduce their costs.

Is that going on anywhere? Is there any network where you see a major provider saying, when possible, you should prescribe tele -- or you should utilize telehealth as opposed to XYZ because it's more cost effective?

MR. TRACY: I don't think they're pushing that. I think they're -- as you see in -- in the written testimony in terms of the commercial payers in some of the states, some of them have just recognized what this can do and -- if we can get patients to specialists earlier rather than later.

And so some of them in some states

have stepped up and agreed to pay for it. You know, I guess as we still -- we still have some convincing here to do in Pennsylvania in order for that occur.

And I think we're on the right track right here.

REPRESENTATIVE BOYD: And it seems odd to me with -- with what I see going on in terms of the negotiations between the provider networks and the insurance carriers and what reimbursements rates, there's this -- there's this incredible tension to reimburse at cost less, cost less, cost less down to, you know, MA in Pennsylvania is at 20 percent roughly of -- of the charge and that there's this built-in incentive within that environment to lower costs and if this would lower costs that much, I just can't fathom that the practical -- that the marketplace hasn't really kind of ushered that in at this point.

I mean I'm -- you know, with respect to the prime sponsor, I'm always suspicions of legislative fixes. I think the market fixes things.

Now, that said, I understand that we

are legislators and there are times when we need to make laws. And maybe this is one of those times.

It just seems odd to me that the insurance marketplace hasn't discovered the potential wonderful savings that they could recognize and then lower premiums for all of us, which is what Chairman DeLuca and I, one of the eight things we always agree on.

MR. TRACY: But one of the more interesting little anecdotes that I have, the Governor of Missouri then, when I was there, was Bob Holden, and he funded a great deal of our telehealth network to actually roll this out to all hospitals with the bioterrorism funding and all of the federally qualified health centers in the state.

I was with the Governor on one particular visit to a very, very rural area of Missouri, and he actually sat in on a dermatology follow-up case back to the university with the patient.

And after exiting the room with the doctor, the doctor just shook his hand and just wouldn't let go, thanking him for putting

this technology in place, and then he said, I've been treating this patient for three or four months unsuccessfully and now I've turned this patient over to the dermatologist and in two weeks she's cured.

So you got a whole lot of primary care doctors who are very good doctors, but sometimes you just have to see a specialist.

And if you turn them -- and that Center for Information Technology report shows, you know, a billion dollar savings figure just in the ability to have this technology to get the patients to specialty care a little bit faster.

CHAIRMAN DELUCA: Is that it?

REPRESENTATIVE BOYD: Yeah.

CHAIRMAN DELUCA: Representative Cohen.

REPRESENTATIVE COHEN: Thank you.

You testified you got into this at the policy level first in Washington and then you're going to Missouri?

MR. TRACY: I was at the University of Missouri when I got an interest in the policy aspect of this.

REPRESENTATIVE COHEN: Could you discuss the evolution of the existing program at Lehigh University?

MR. TRACY: Yeah. Well, at Lehigh Valley Hospital and Health Network?

REPRESENTATIVE COHEN: Lehigh Valley Hospital.

MR. TRACY: Their entry into telehealth started with the advanced ICU. This is an advanced ICU where an intensive care physician sits off-site from 7:00 p.m. to 7:00 a.m. He or she is flanked by two critical care nurses, and they monitor 128 ICU beds each night.

So if you are a patient in one of those ICU beds, all of the monitoring devices that are connected to you are feeding to the electronic medical record once a minute.

If anything -- if any one of your clinical indicators goes in a bad direction, the intensivist knows it within one minute. You have access to the packs and all the imaging systems, the lab systems. They have computer physician order entry to get your medications entered quickly.

And one of the really nice things, by tying this all together, is that the nurses now in the critical care units have approximately 90 minutes per 12-hour shift in direct patient care time because they're not doing nearly the paperwork that they used to do.

So it -- it augments the critical care environment in the daytime. It does wonderful things. It's reduced mortality by five percent in the moderately critically ill. And it has also reduced length of stay by half a day for that same population.

So that was their entry into it. Right now we're starting up the maternal fetal medicine services up in the Montage Mountain which is in Moosic, PA.

We're working with Good Samaritan Hospital in Pottsville on a trauma program where we're putting a -- our regional burn center out there is using Steorn forward technologies to the EDs where we -- where we work so that burn cases can be triaged, examined, and treatment started earlier, before that patient is transferred to Lehigh

Valley or some other burn centers.

We do --we also do home health in the same manner that was described with about a 150 monitors out there every day taking care of patients with chronic disease.

So a lot of activity going on.

REPRESENTATIVE COHEN: Thank you very much, Mr. Chairman.

CHAIRMAN DELUCA: Representative Nickol.

REPRESENTATIVE NICKOL: There seems to me to be different levels of telemedicine and telehealth.

Do any states reimburse for an e-visit or if I just send an e-mail to my GP saying Johnny is running a temperature of a 101 and has sniffles. What should I do?

MR. TRACY: When you say sniggles (sic), are you talking like the Medicaid programs, Medical Assistance programs, are they paying?

REPRESENTATIVE NICKOL: Or can the states require commercial insurers to cover? I mean I guess I know what e-mail has done to me in terms of constituent contact.

MR. TRACY: Good or bad?

REPRESENTATIVE NICKOL: And we talk about utilization being a primary factor in controlling health care and driving health care costs. So what I'm looking to you is, are we -- is this going down to that level where you're -- you're advocating equal reimbursement for me just being a concerned parent and e-mailing my GP as opposed to taking Johnny in to see him, which does this create a barrier to me taking Johnny?

MR. TRACY: Well, there's a big debate on the e-visit right now from a standpoint of we see Aetna or Cigna advertising that -- or promoting that they're going to be paying for the e-visits but only with a specified program, pretty much only tied to your -- you know, to your existing primary care provider.

But there are others that will argue, well, heck, I can pick up the phone and just call and just call him and it won't cost me anything.

There are -- there are companies that you will see coming out that will basically

say, well, slide your credit card in the slot and you'll be able to log on and see a doctor of your choice, licensed in that state, and -- and will charge the patient directly.

And some health plans are beginning -- beyond Cigna and -- and Aetna are also beginning to look at this as a way of care management of existing patients.

REPRESENTATIVE NICKOL: Are they charging copayments? I mean right now if I take Johnny to the doctor, I have to pay a $15 copay which does create a barrier as well.

MR. TRACY: Right.

REPRESENTATIVE NICKOL: I would imagine that if you could put some deterrent in there to make sure it's a serious contact it might control the utilization.

MR. TRACY: Right. I believe if the health plans get into this, the copayments will be collected. Even the Med -- even the Medicare program with the telemedicine reimbursement, copays still apply. So I can't imagine that changing.

CHAIRMAN DELUCA: Joe, just -- I find it interesting here. I'm looking at the

Highmark testimony that they sent us over here, and they do cover radiology, pathology, patient monitoring.

But they also do state in here the fact that Highmark has a longstanding tradition of protecting the consumers from treatment methodologies that are not fully proved to be effective.

And they say the potential to expose health care consumers to services that could be harmful if not provided during direct, face-to-face contact with their physicians. The broad nature of the bill raises questions not only about the quality of health care, but also costs and medical liability.

What do you say to those, to their remarks?

MR. TRACY: Well, sitting at Lehigh Valley Hospital, we entertained about two weeks ago five insurance specialists from the Centers for Medicare and Medicaid Services. And during that time they met with four or five chairman of different clinical specialties and chiefs of those specialties.

And, you know, I sound like I'm

bragging, but Lehigh Valley is recognized as one of the best hospitals in the world. I can't imagine the chiefs and the chairs of those departments wanting to get into telemedicine if it was unsafe and not proven and --

CHAIRMAN DELUCA: Well, it's -- if you're saying we're going to save this cost --

MR. TRACY: Right.

CHAIRMAN DELUCA: -- and you're saying it's safe, you see this Highmark, which has about 75 percent of the market in western Pennsylvania, I'm just wondering, haven't we educated the providers -- I mean the insurance carriers on their savings or are we doing a bad job, are -- not we, because we're not involved with the telemarketing -- telehealth, but are you -- are we -- is the profession out there and this new technology, you're not educating the carriers about this or what?

MR. TRACY: I think we can do a better job of that. In fact, right now our medical director of our physician hospital organization is inviting the medical directors in from the private insurance companies for a

demonstration, similar to what we gave CMS, so that they can see what we're doing is not only high quality and -- you know, sometimes for most patients this is the difference between care and no care.

And if you continue, like that patient in Missouri, to go back to that doctor, being treated over a three- or four-month period unsuccessfully but then within a two-week period being taken care of, you know, you got a lot of costs on the front end that could have been avoided.

CHAIRMAN DELUCA: Well, I want to thank you for your testimony. Certainly we look forward to working with you.

MR. TRACY: Thank you.

CHAIRMAN DELUCA: Thank you very much.

Lastly to testify is Martin Ciccocioppo. Is that -- is that correct?

MR. CICCOCIOPPO: You got that correct.

CHAIRMAN DELUCA: We asked you if that was the correct --

MR. CICCOCIOPPO: That is correct,

Mr. Chairman.

CHAIRMAN DELUCA: All right. Welcome.

MR. CICCOCIOPPO: Thank you. And in interest of time, I'll just highlight a few remarks from my written testimony and then be able to take a few questions.

Again, my name is Martin Ciccocioppo. I'm the vice president for research for The Hospital and Healthsystem Association of Pennsylvania.

I'm also the chairman of the board of Pennsylvania eHealth Initiative. The Pennsylvania eHealth initiative started in 2005. It's a broad-based public/private partnership which is committed to fostering the adoption and use of health information technology, electronic medical records, and health information exchange in the Commonwealth.

I appreciate the opportunity to present the views of the hospital association on House Bill 1849 and the need to increase the use of health information technology to improve access, quality and affordability of

health care.

Each year Pennsylvania hospitals and health systems give healing, health, and hope to nearly two million inpatients, 33 million outpatients, five million in emergency room department visits, and the hospitals are committed to the adoption of health information technology to improve the quality of patient care and advance efficiencies in the delivery of care.

Pennsylvania hospitals have carved out a leadership position, which you heard from UPMC and Lehigh Valley, in the adoption of health information technology as compared to their peers.

Provided with my written testimony is a copy of the report the hospital association prepared last year based on the findings from a national survey that favorably presents the adoption of health information technology to Pennsylvania hospitals when compared to the rest of the country, both in timing -- in terms of adoption, actually user technology, spending on health information technology, and also highlighting, as you might guess, that

one of the major barriers to health information technology adoption continues to be the cost of implementation as well as the ongoing hospital operating costs.

As you debate requirements around information technology, there are several critical points that must be considered.

One: Hospitals aren't interchangeable, as well as physician practices aren't interchangeable.

The speed -- the speed of clinical information technology adoption is expected to provide more improvement in the next 20 years -- 25 years than has occurred over the last 100 years.

The costs to implement health information technology are significant.

And we caution against mandating specific information technologies or specific products in favor of allowing the market to evolve and foster the best adoption for providing the right care at the right time for all patients in Pennsylvania.

HAP and its member hospitals and health systems applaud the intent of House

Bill 1849 as a means of encouraging the adoption and use of health information technology in the form of telehealth to provide greater access to appropriate and necessary, quality, and safe care in Pennsylvania.

Health information technology proposes that incorporate -- proposals that incorporate health information technology should recognize that the good of all patients must be a priority;

That individual patients must be the core focus of health care -- of the health care system and the implementation and adoption of health information technology;

That the health care system must work for all Pennsylvanians;

And that the best elements of our health care system must be preserved and enhanced.

House Bill 1849 focuses on expanding the use of telehealth in Pennsylvania by requiring insurers to provide for the health care services delivered through telehealth, when appropriate, and when such services can

result in lower costs.

This legislation is likely to have a limited impact since it does not cover federal programs, such as Medicare, and many private insurers would not be required to follow the requirement since federal law would preempt them from following this state mandate.

HAP recommends that the House consider Senate Bill 8 which passed the Senate unanimously in June -- on June 5th of 2007 and would provide for public investment in health information technology.

The bill is pending in the House Health and Human Services Committee.

In addition, we call your attention to Senate Bill 340. This bill, which was recently approved by the Senate Public Health and Welfare Committee, is similar to House Bill 1849 but it's limited to requiring Medical Assistance payments for telemedicine services.

Adoption of these legislative initiatives would help to stimulate the development of health information technology in the Commonwealth.

In furtherance of the adoption of health information technology, the Pennsylvania eHealth Initiative was asked by the administration and the Governor's Office of Health Care Reform to investigate the ways in Pennsylvania in which we could foster the adoption of electronic health records and e-prescribing, as well as the health information exchange.

I provided the executive summaries of two white papers that were recently delivered to the Governor's Office of Health Care Reform and the administration.

Those papers, again, address building a sustainable model for health information exchange in Pennsylvania and establishing widespread adoption of electronic health records and electronic prescribing in Pennsylvania.

The executive summary contains an overview of the issues as well as a summary of the recommendations coming out of the papers, which each -- each of which is 30 to 40 pages.

And I invite you to visit the

PAEHI.org website for the full text of those white papers, as well as our strategic plan for implementing or fostering the adoption of electronic health records that means connecting Pennsylvanians for better health.

It was issued last spring by the Pennsylvania eHealth Initiative.

In summary, HAP and its member hospitals and health systems, as well as the Pennsylvania eHealth Initiative, welcome the opportunity to work with the Administration, the General Assembly, and with other stakeholders on advancing the use of health information technology.

Again, I thank you for the opportunity today to present the hospital community's view on health information technology and our commitment to improve health care for the patients we serve.

We also appreciate your willingness to engage in a public dialogue, and I will be happy -- more than happy to answer any questions at this time.

CHAIRMAN DELUCA: Thank you, Martin.

Any questions? I guess you did a

good job.

MR. CICCOCIOPPO: Okay.

CHAIRMAN DELUCA: And appreciate you taking the time to come.

MR. CICCOCIOPPO: Very much past lunchtime.

CHAIRMAN DELUCA: Well, thank you. Thank you very much.

I want to thank all the members for attending the meeting today and certainly the people testifying for taking their time to come here on this innovative idea on telehealth. And this meeting is now adjourned. Thank you.

MR. CICCOCIOPPO: Thank you.

(The proceedings were concluded at 12:14 p.m.)

I hereby certify that the proceedings and evidence are contained fully and accurately in the notes taken by me on the within proceedings and that this is a correct transcript of the same.

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Brenda S. Hamilton, RPR
Reporter - Notary Public