COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

PROFESSIONAL LICENSURE COMMITTEE
PUBLIC HEARING

STATE CAPITOL
HARRISBURG, PA

NORTH OFFICE BUILDING
HEARING ROOM #1

WEDNESDAY, SEPTEMBER 12, 2018
9:33 A.M.

PRESENTATION ON SB 780 (VOGEL)
TELEMEDICINE

BEFORE:
HONORABLE T. MARK MUSTIO, MAJORITY CHAIRMAN
HONORABLE ROSEMARY M. BROWN
HONORABLE JIM CHRISTIANA
HONORABLE GARY DAY
HONORABLE KEITH GILLESPIE
HONORABLE SUSAN C. HELM
HONORABLE DAVID S. HICKERNELL
HONORABLE JERRY KNOWLES
HONORABLE ZACHARY MAKO
HONORABLE THOMAS L. MEHAFFIE III
HONORABLE STEVEN C. MENTZER
HONORABLE MARGUERITE QUINN
HONORABLE CURTIS G. SONNEY
HONORABLE HARRY READSHAW, DEMOCRATIC CHAIRMAN
HONORABLE TIM BRIGGS
HONORABLE CAROLYN T. COMITTA
HONORABLE DOM COSTA
HONORABLE WILLIAM C. KORTZ II

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Debra B. Miller
dbmreporting@msn.com

ALSO IN ATTENDANCE:
HONORABLE BRYAN CUTLER

COMMITTEE STAFF PRESENT:
WAYNE CRAWFORD
MAJORITY EXECUTIVE DIRECTOR
KELLY ROTH
MAJORITY LEGISLATIVE ADMINISTRATIVE ASSISTANT

MARLENE WILSON
DEMOCRATIC EXECUTIVE DIRECTOR
KEONTAY HODGE
DEMOCRATIC LEGISLATIVE ADMINISTRATIVE ASSISTANT

I N D E X

TESTIFIERS

* * *

TESTIFIERS (continued):

SUBMITTED WRITTEN TESTIMONY

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See submitted written testimony and handouts online under "Show:" at:

http://www.legis.State.pa.us/cfdocs/Legis/TR/Public/trfinder public action.cfm?tr doc typ=T&billBody=&billTyp=&billNbr=&hearing month=&hearing day=&hearing year=&NewCommittee=Professional+Licensure&subcommittee=&subject=&bill=&new title=&new salutation=&new first name=&new middle name=&new last name=&new suffix=&hearing loc=

P R O C E E D I N G S

* * *

MINORITY CHAIRMAN READSHAW: Good morning, everyone.

Good morning. I would like to thank everyone in attendance for being here this morning. We do have a capacity crowd.

I am Representative Harry Readshaw. I am the Minority Chair. And the Majority Chair, Representative Mark Mustio, requested that I preside temporarily to give him the opportunity to make appropriate remarks this morning.

So with that, may we call the roll, please.

(Roll call was taken.)

MINORITY CHAIRMAN READSHAW: Thank you.

As we all know, this is a hearing calling for the familiarization and education of Senate Bill 780 that was voted unanimously from the Senate and directed to the consideration of this House Professional Licensure Committee.

As you may observe on the agenda, this hearing will convene until 1 p.m., and so there's three things that I would like to request. I would like to request anyone

that must excuse themselves will do so in a respectful manner; the Committee Members will be coming and going as their responsibilities dictate; and obviously, we must observe and stay on the agenda, as the time limits will be observed.

With that, I will recognize the Majority Chair, Representative Mark Mustio.

MAJORITY CHAIRMAN MUSTIO: Thank you, Chairman Readshaw and Members of the Committee.

This is most likely the last Professional Licensure Committee hearing of this session. I wanted to take the time to thank you for your active participation on this Committee.

Second, it's not common that a Chairman of a committee has to justify why a piece of legislation is in their committee, but because we have seen so much correspondence saying it should be in the Insurance Committee, I wanted to address that issue.

In the packet, the binder, I have provided a copy of the June 8th memo written to Members of the Senate from the Insurance Federation and the Blues regarding the gut-and-replace amendment in the Senate. The first sentence in the second paragraph in that memo says, "We appreciate the bulk of this proposed amendment deals with licensure issues, ensuring that telemedicine be responsibly

practiced and regulated among all types of providers."

The morning of June 19th, I was driving the Speaker back from an early morning speaking engagement, and he received a call from an insurance lobbyist making the case as to why the bill should go to the Insurance Committee. I must admit, that raised my eyebrows.

I leave it to each of you to decide what the reason and motivation for wanting the bill to go to the Insurance Committee was. But from my point of view, the fact that the lobbyist was making calls to intercede on process was concerning to me, enough so that I began to ask what committee would give this bill the thorough review that it deserved and made our case to the Speaker's Office, and when I say "our case," I'm speaking about every Member of this Committee.

I will put this Committee up against any in the House for the ability to deal with issues from competing interests. You know them well, but for the audience and the insurance companies that don't regularly appear in front of this Committee, I'm going to give you some examples: physicians versus nurses; ophthalmologists versus optometrists; anesthesiologists versus nurse anesthetists, and on and on. In other words, we act like Solomon on a regular basis. We deal with scope-of-practice issues all the time.

Also, most times that a medical profession seeks licensure, it's to entitle them for reimbursement, insurance reimbursement, and reimbursement is a subject discussed in this bill.

Personally, I have been in the insurance business since 1979, working for Aetna as an underwriter and then for the last 37 years as a broker; in that capacity, seeing insurer and provider points of view on a regular basis.

Insurance is an incredibly important part of our economy and our lives. Every day, we transfer risk to health insurance companies by paying a premium. By paying that premium, that frees up other money for us to invest in our homes, cars, and education.

Imagine if we did not have insurance and had to put money aside to pay for a catastrophic medical procedure. That being said, insurers are not always right. They try to limit risk. One of the first lessons I learned working for Aetna is this example: An insurance company's ideal risk to insure is a piece of steel under water to insure it against fire.

Let me give you an example of a piece of legislation that was signed into law that the insurance industry fought vehemently but has turned out to be highly successful.

When Governor Casey was in office, the full tort/limited tort auto insurance bill was signed into law. As part of the law, if a customer selected limited tort, the insurance company had to reduce rates by 12 percent. Insurers went ballistic, so much so that Aetna was going to pull out of the State for automobile insurance.

It just so happens at the time that Governor Casey was insured by Aetna, and I remember the cartoon in the newspaper depicting him opening up his cancellation notice in the mail. I remember that well, and the actions of the insurers makes it clear that this is the committee to review this bill.

I committed to keep Chairman Pickett in the loop. I committed to not put my finger on the scales. I traveled to her district for a telemedicine demonstration at Guthrie Hospital.

I also want to thank Garth Shipman and Alan Cohn, the majority and minority staff on the Insurance Committee, for their valuable input in meeting with myself and also participating in staff-only meetings.

In addition, I want to thank Senate staff for hours of time meeting with me and our Committee and Insurance Committee staff.

And, of course, as the Committee knows, Wayne and Marlene, you have been great in this process.

Kelly, thank you for putting the binder material together.

And I want to recognize Representative Quinn -- I'm not sure if she's in the room at this point, but she's planning on attending today -- for her leadership on this issue. She has spent the last year and a half working with the Senate on this legislation, and I appreciate her taking the time to be here later today.

Let me make it clear: This bill should not be used to settle the big-picture reimbursement disputes between insurance companies and providers. As one insurance company has said, this bill should compensate health-care providers for their professional medical evaluations and treatment. It should not be a source of guaranteed revenue for device manufacturers. This bill should not be a vehicle guaranteeing seed capital for experimental telemedicine.

Now, at this time, I would like to review the binder. This is a little bit different than we normally do. We get packets of testimony, but what I wanted to run through with you in your binder, just to give you an idea of what has taken place over the last couple months, you'll see a time line.

The bill was assigned to this Committee on June 19th, and I have listed every meeting that I have

participated in, every demonstration that we participated in, across the State.

And keep in mind that the reason we had demonstrations done across the State, prior to those demonstrations, I traveled the State to see what would be the most appropriate ones for Members to see. It is an election year, it was summer vacation time, and I thought that it would be most appropriate, since I am not running for reelection, to invest the time to make sure that we could properly vet this issue.

So you'll see the multiple pages of meetings, whether it was with insurance companies, meeting with providers, seeing demonstrations. It totals about 50, and that doesn't include any of the staff meetings that we had discussing this issue.

The next page shows the number of States that have already enacted parity telemedicine laws. Now, I'm not a proponent of one that says just because it's done in another State that it needs to be done in our State. We all know that the procedures and the way we operate in Pennsylvania and all States aren't the same, but I think it does raise some eyebrows again as to, you know, other States who are adopting this.

In one of the conference calls with an insurance company and a provider, it was brought out that the

national commercial insurers are saying that providers cannot use certain telemedicine delivery platforms because of the national companies that provide what I like to call the sore-throat doctor?

You know, we have all seen, those of you that attended the demonstrations, you have seen the specialist demonstrations at the provider hospitals. But you have probably also seen where if you get a sore throat, you're away on vacation, a lot of times you can dial up -- right? -- depending on your health insurance plan to get treatment on weekends, maybe when your doctor is not in.

So there are companies that do that, and Teladoc is one of them. And I have a letter in the binder here saying that they absolutely do not require exclusivity. There's another letter a little further back in the binder from Amwell that says the same thing.

Also included, the next letter there is the letter that I addressed in my opening comments, highlighted there in yellow, stating that this is a licensure, primarily a licensure bill.

The Insurance Federation on September 10th sent an email to all of us on the Committee, and it was addressing the legislation. I forwarded that email to Garth Shipman on the Insurance Committee, and the comments that Garth made are in red for all of you to digest.

One of the things that was very telling was when, one of the demonstrations, Representative Mako was not going to be able to attend a demonstration that we had set up in his area, so he came with myself, Wayne, I'm not sure if Marlene attended that one or not at Geisinger, but Garth Shipman was there, and one of the things that really was astounding at our discussion afterwards was that Geisinger didn't say a word about problems with reimbursement.

In fact, they had a handout for us, and that's the second. You see the first one is from Lehigh Valley Health Network. The second one is from Geisinger, and you'll see that almost everything is in green. So they're being reimbursed from all of their insurers. I was taken aback, so much so that I had to send a couple follow-up emails saying, are you sure that you're being reimbursed?

So what we did was we asked other providers that we had already gone and seen around the State that had problems with reimbursement and had them fill out the same grid, and we still have a few more that are coming in. But you can see on the others that there are some partial payments. There's a lot of red. Penn Medicine is almost all red. UPMC has some reimbursement. There's no comment on here whether that's primarily from their own, from their own health plan.

One of the things that I asked for, I was preparing an Executive Summary for the leadership team on this issue, and Independence Blue Cross was kind enough to provide a list of questions for the provider community. So that's the next section that you have there.

There were 10 questions that they asked. I will tell you that these answers are provided by Penn Medicine, but I thought they were very thorough and they were excellent questions, and the answers I thought were very informative for all Members.

At the conclusion of their response, though, they did also include potential questions to ask the insurance community. So there's four questions there.

Now, finally, in the back of the -- and I'll conclude my remarks. Finally, in the back of the binder you'll see the telemedicine health policies for Aetna, Capital, Cigna, Highmark, Independence, UnitedHealthcare, UPMC, and Geisinger. And the reason I provided those to you is in your spare time, when you want to start reading insurance policies, it will show you certainly the diverse application of telemedicine across the State.

So I think that pretty much summarizes what I had to say, other than a few more thank-you's.

I wanted to take the time to thank UPMC, UPMC Health Plan, Geisinger Health System, Geisinger Health

Plan, Allegheny Health Network, and Highmark. All of those are what we would call integrated systems and come at this with a little different approach. In fact, Allegheny Health Network and Highmark will be testifying.

I also want to thank the Lehigh Valley Health Network Community Services Group, Penn Medicine, the Children's Hospital of Philadelphia, the University of Pittsburgh, and Guthrie Medical Group, all of whom made themselves available for demonstrations.

And finally, I would like to thank Independence Blue Cross and Capital BlueCross for multiple meetings, several of which were set up at the spur of the moment, but they were able to accommodate myself and even Representative Quinn on a very short basis.

At the front of the book, binder, you'll see that there is a Highmark commercial medical policy, and in there it talks about medical necessities and the appropriateness of clinical care.

Thank you, Mr. Chairman.

MINORITY CHAIRMAN READSHAW: Thank you, Mr. Chairman.

If I may, just on a personal note, add something.

I have been a Member of the House for 24 years now. I have also been a Member of this Committee for 24 years, and I would just like to respectfully thank the

Majority Chair. Over the summer, as we know as Committee Members, he has, through his hard work and diligence, he has provided many opportunities to us to see demonstrations on telemedicine. He has been devoted to this subject, and we thank him very much.

Next, I would like to introduce the Majority Whip, Representative Bryan Cutler.

MAJORITY WHIP CUTLER: Thank you, Chairman Readshaw and Chairman Mustio.

To go along with the unusual nature of having the Chairman open the committee hearing in this manner, I think we'll continue with that with having me share my own personal experience, not only with the legislation but also what I did prior to coming to the Legislature, because I think it has particular bearing on this proposal.

For many of you who may not know, prior to joining the Legislature and prior to becoming an attorney, I started out life as an X-ray technologist. And while I was at Lancaster General, I eventually went to school, had a degree in health-care administration, and became the Manager of Support Services for radiology at Lancaster General.

In those duties, I was the PACS, the Picture Archival Communications System, which is digital X-rays, System Administrator, as well as the individual responsible

for the billing, coding, and charging for all of the radiology procedures done in the health network. The reason I share that is because that's really where the interest in this bill for me began, because even nearly 20 years ago, we were already doing a version of telehealth at that time.

We had, in our PACS network, we had multiple sites -- we had outpatient clinical sites; we had the hospital proper -- and we would share radiology images over the network at that time. We would archive the images at the hospital. We would distribute them out remotely to the multiple facilities or the outpatient centers or physicians' offices where patients were going, and we were responsible for all of that.

And the reason I share that is because this is not necessarily a new technology. Some of the issues that we'll encounter as we discuss the bill may be new, but I would actually offer that all we need to do is think about them a little differently and come up with slightly different solutions, because we were able to overcome them nearly two decades ago when we were there and I think we'll be able to overcome them today.

When we were at the system, it was fairly easy in terms of reimbursement because everything was in-network. It was the same providers, it was the same radiologists,

and everything was consistent inside our system.

As I left that job and decided to go to law school, and prior to running for office, I worked at a facility where we used what they called NightHawk services, which were off-site radiologists, oftentimes in Australia because of the time zone differences, where when I worked nightshift, we would actually send our radiology films via the Internet to a secure server, have them reviewed. We would give a preliminary report to the emergency room at that time, and then they would be reread in the morning. And then we had a quality-control process in place to ensure that nothing was missed.

Now, that certainly raises some questions of State licensure and credentialing and a whole host of other issues, but the important factor to understand is, they were all taken care of 15 years ago, and they were consistent with delivering quality patient care, timely film interpretation, and getting patients on their way.

Any time that we discuss issues like this -- and this is really, I think, the important part -- there's three components to the delivery of health care, and every time that we make a change, you're going to impact at least one of them, and they are as follows: It is cost, quality, and access. And every component that we work on will influence one either to the good or to the bad as you move

each one.

I would offer that this actually offers opportunities for increased access, also offers opportunities for lowering costs, potentially, and also improving patient access in terms of rural and urban areas that may not have the opportunity to have specialists. If you look at our medical population, it unfortunately is trending upward in terms of age, and there are not as many people coming in at the bottom as are going out at the top in terms of retirement.

So when you look at it, I think this is a new tool in the toolbox that could be expanded, potentially, to better allow health-care providers to continue to meet our growing health-care needs and improve patient care. I think it can greatly enhance the outcomes in terms of timeliness, quality, and access for delivery of service, particularly in rural areas.

The example, while it was not one of the Chairman's, it was a demonstration of telemedicine that I saw 2 years ago with the Policy Committee, was where you have cases where individuals might have a stroke and you need to go in for a specialized kind of treatment. That can be very expensive in terms of running blood thinners. Well, if you're in a remote facility, there's transportation costs involved, and you need to make sure

that that individual is having a stroke. So they would at first do a telemedicine review to make sure that the symptoms were consistent with what that was prior to moving the patient.

It was a very unique approach. They were able to look at the CAT-scan images, the CT images of the head. They were able to do the evaluation via real-time video feed. And then they would make a clinical determination as if they were there, and they were able to deliver better patient care. And if it wasn't a stroke, then they didn't have to unnecessarily burden the patient or increase costs by moving them. And I think that's a good example of where it can improve patient care and potentially lower costs.

I also think that telemedicine has the potential to reduce the loads that we're currently experiencing in our ERs, in our emergency rooms. When you look at what a lot of folks use emergency rooms for, unfortunately, it's not always truly emergent cases. That's something that I know Representative Gillespie dealt with in his prior career, as did I in terms of our volumes.

When you look at the volumes of cases that come to the hospital, they're not always being cared for in the appropriate places. Many individuals don't have a primary-care physician, so they end up using the emergency room as one, and that's one of the most expensive places to

deliver care. So if you can increase opportunities to deliver primary care in a more cost-effective setting, you will, through that, overall lower health-care costs.

I know that we had our staff research it. Mental health is a particularly great field where I think this could be expanded -- telemedicine, wellness intervention. A triage referral program was run in Texas where they were able to administer services, and I know that in the Norristown Area School District and the Children's Hospital of Philadelphia, they piloted a program here. So I think that those are things that we can look at in terms of how were these issues of credentialing, licensing, reimbursement costs, how were they handled and how were they addressed in terms of any of the questions that we had.

The other area is a particularly personal one for me, because it's the delivery of senior-care services.

I had a close, personal family friend who, unfortunately, through miscommunication between the long-term-care facility that she was at and the hospital where she was supposed to go for follow-up after a very complicated surgery, where the physicians worked miracles and saved her life, she was sent to a long-term-care facility to rehab. She did not get the appropriate follow-up and care that she needed, and she ultimately

developed other complications related to the missed appointments and then passed away. And in a case where you didn't have to physically transport the patient back and forth from the long-term-care facility to the hospital, I think that there's an opportunity for improved patient care, improved outcomes, and ultimately lower costs as well.

So to bring everybody back to those three issues, I think this potentially addresses costs, it potentially addresses access, and it potentially addresses quality, and I think there are opportunities in each of those.

I think too often here in the Legislature we get inundated with all of the reasons why we cannot do things. You know, we'll hear a lot of reasons why we shouldn't tackle an issue. And, you know, this issue is one that I started a while ago because of my own personal background, but I was more than happy to defer to Representative Quinn and the other individuals because they had more of a head start on me in terms of drafting, and I think they were better positioned to move the issue forward.

I want to thank her for her work on this, and I'm more than happy to work with them as we move this through the process. I'll be happy to share any personal experiences that I have had through my nearly two decades in the health-care field.

But rather than focus on all of the issues, and I can briefly run through them because I think it's important, because I'm assuming -- I have not read your binder since I'm not a Member of the Committee, but these are the issues that I dealt with 15, 20 years ago when I was working there. You know, there is issues of licensing and credentialing. There is potentially issues related to the resolution of the computer monitors that things will be viewed on. There's issues of billing, coding, and charging; provider and network issues. There's contractual relationships with those provider and network issues, and there's HIPAA and privacy concerns.

All of those issues are addressable, in my experience. We addressed them when I was at Lancaster General back in '99-2000, 2001. I think that we can still address them today.

And my word of encouragement to the Committee as you work through those issues is, our laws should encourage this type of development and make it so that this technology can be used and expanded on behalf of the patients and on behalf of quality patient care.

And we shouldn't have laws in place that simply discourage new development, because I think we all have experiences outside of this particular realm where we all agree that things haven't been updated since the eighties

or the nineties, and technology has far outpaced the ability of our statutes to keep up.

And that's probably one of the biggest complaints that I hear from individuals outside of the legislative process, is, you know, why hasn't that law been updated since 1984, or, you know. In some cases, you know, we come across stuff, the hospital licensing bill, the last big omnibus rewrite that myself and Representative DeLissio worked on. That took three decades to get done, and unfortunately, technology moves at a much, much faster pace than that.

So I just encourage everybody, look at the potential. Let's solve the issues, because I think they're absolutely solvable. Ask good questions, and let's focus on the solution, because I think that's what our constituents who ultimately, hopefully aren't patients, but when they are, they're going to want that to be the answer.

So thank you for your time, and I'll be happy to come back and answer any questions. I saw the question time period is at a later time, so.

MAJORITY CHAIRMAN MUSTIO: Here's an empty seat, too.

MINORITY CHAIRMAN READSHAW: Thank you, Representative Cutler, for your remarks.

And at this time, I will relinquish the Chair back to the Majority Chair, Representative Mark Mustio, and I certainly hope you all enjoyed my brief appearance.

MAJORITY CHAIRMAN MUSTIO: Okay, Chairman Readshaw. You have let this meeting get behind schedule.

MINORITY CHAIRMAN READSHAW: May I rebut that remark?

(Laughing.)

MAJORITY CHAIRMAN MUSTIO: You may.

Never give elected officials a microphone.

Okay. At this time, I would like to recognize Judd Hollander for his remarks.

DR. HOLLANDER: Good morning, Chairman Mustio, Chairman Readshaw, and Members of the Committee. On behalf of The Hospital and Healthsystem Association of Pennsylvania, Jefferson Health, and Pennsylvania's hospital community---

MAJORITY CHAIRMAN MUSTIO: Is that microphone on? Push the -- there we go. Thank you.

DR. HOLLANDER: ---as well as patients, thank you for holding this important hearing on telemedicine and Senate Bill 780 and for your dedication to understanding the complex world of health care and efforts to improve the quality of life for citizens of the Commonwealth of Pennsylvania.

I bring a unique perspective, I think, in this hearing, as I both run a telemedicine program and I'm still a practicing emergency physician who sees patients in the emergency department, urgent-care centers, and via telemedicine.

And you'll notice that with respect to technology, I am reading off my computer, but I'm smart enough to have backup copies of paper, much like when we do telemedicine.

I'm hopeful that most people in this room are familiar with the concept of the Triple Aim as discussed by Mr. Cutler. We all share the challenge of simultaneously reducing per capita costs of health care, improving the patient experience, and improving the health of populations. Telemedicine is one really good way to accomplish these goals.

Specifically, Senate Bill 780 would:

- Define telemedicine;
- Would protect patients by outlining who can provide health-care services through telemedicine;
- Would require health insurers to provide reimbursement for telemedicine services if they pay for the same service in person; and

- Would bring consistency to the reimbursement process.

Within the next 15 minutes, I will clarify five major points:

- Telemedicine is simply a type of care delivery mechanism that can be used for some patients some of the time to provide high-quality care. It's just a care delivery mechanism.
- Telemedicine positively impacts access, cost, experience, and effectiveness of care.
- Despite complaints about the rising cost of care, patients in the Commonwealth are being deprived of a lower cost care option.
- There are already ample protections in place to ensure appropriate care is provided through telemedicine.
- And care rendered through telemedicine technology should not be held to a higher or different standard of care than that received through other modalities just because the technology is used. Medical care is medical care.

Telemedicine is not a new type of medicine. It's simply a care delivery mechanism. You'll hear that a couple of times. It is one modality, one mechanism, for delivering care, not a different type of care.

Simply put, telemedicine, or telehealth, is the delivery of health-care services provided through telemedicine technologies to a patient by a remote health-care provider. Two-way video, smartphone, wireless tools, and other forms of technology can be used to deliver this high-quality care.

Telemedicine helps to provide access to quality, convenient care while keeping costs down and improving health outcomes and population health. It allows patients to access physicians and specialists located around this State while those patients remain in their own communities, surrounded by their own support systems.

Telemedicine solves access problems in rural and urban areas and suburban areas. There are tremendous specialist shortages in some of your rural areas around the State, but there are actually appointment shortages in urban areas. Thus, it's important to remember it's about patient access rather than geography.

One timely example in the news these days is telemedicine's ability to amplify the reach of providers capable of intervening in the opioid crisis, and this is a

recommended use of telemedicine through the Federal Opioid Crisis Response Act of 2018.

But other things telemedicine can do is:

- Eliminate waits for in-person appointments and travel time;
- Address school safety through in-school behavioral health problems;
- And it can actually save lives when seconds matter.

We know it can save lives when you're a stroke patient or in a cardiac arrest and we can bring in the specialists, but I offer you a different thing: It can save lives even when it can't treat the patient.

One example is, a colleague of mine took a call from someone on New Year's Eve about a child that had belly pain while she had a party at her house. My colleague in telemedicine, Dr. Phillips, saw the child and was actually concerned that the patient had appendicitis. The patient was sent to CHOP, where they went to the operating room. Mom and dad had to leave the party at their house to take care of their child.

You can tell what would have happened if that patient wasn't seen. She would have been sent upstairs to

bed, and there would have been a ruptured appendix. We can't treat that by telemedicine, but we can help get patients to the right care spot. A really important point.

The scientific evidence regarding the benefits of telemedicine is beyond question. A comprehensive analysis of 58 systematic reviews on telemedicine outcomes commissioned by the Agency for Healthcare Research and Quality, or AHRQ, examined the impact of telemedicine on clinical outcomes, utilization, and cost.

The report concluded that telemedicine is particularly effective for such applications as:

- Remote patient monitoring;
- Managing patients with chronic conditions, especially relevant in our senior population; and
- Psychotherapy or behavioral health.

Further, the report found measurable improvements in:

- Mortality rates;
- Quality of life; and
- Reductions in hospital admissions; hence; cost.

Outcomes of care provided via telemedicine are at least as good and sometimes actually better than care delivered "in person." The studies are summarized in the written document you have before you. I'm not going to review all of them now, but they show a couple of favorable outcomes for neurologic-care services such as stroke, heart failure, "store-and-forward" image interpretation, like Mr. Cutler talked about with radiography, mental health services, and tele-ICU support.

Within Pennsylvania, the effectiveness of telemedicine has been demonstrated for multiple high- and low-acuity conditions. Jefferson and UPMC have published data that show that more stroke patients receive clot-busting drugs, have better functional outcomes, and yet are able to remain in their own community during treatment rather than be transferred to the urban setting.

Lehigh Valley Network has shown that an advanced ICU model can significantly lower the mortality rate and lower the rate of mechanical ventilation.

At Jefferson we have shown that we can prescribe appropriate antibiotic therapy for sinusitis better than we actually do with the same providers in an urgent care or emergency department setting.

There are reported benefits within primary care, behavioral health, ENT, urology, preadmission testing, care

transitions out of the emergency department, and these are just publications in the last year or two.

And there is higher compliance with something called the Choosing Wisely campaign, which is a multispecialty campaign to eliminate unnecessary testing. One of the advantages of telemedicine is you are unlikely to do extra tests just for the heck of it, because the extra tests you don't get, so you get appropriate testing rather than someone with a headache coming in to the ED and automatically getting a CAT scan that's not necessary and not recommended.

Telemedicine is an essential part of health-care transformation. As hospitals and health systems and providers, we're in the business of making and keeping our patients healthy. Innovation has fundamentally changed how we shop and bank, yet one of our most prized possessions, health, lags behind.

We should be able to use all the tools made available to us in order to improve health. Telemedicine is one of those tools. One day, much like banking is just banking, no longer "telebanking," telemedicine will just be medicine because it's just about taking care of the patient, it's not actually about the technology.

Following the work I discussed completed by AHRQ, the U.S. Department of Health and Human Services called on

the National Quality Forum, or NQF, to convene a multi-stakeholder Telehealth Committee. The committee was charged with developing a measurement framework to assess the quality of care provided by telemedicine. NQF reviewed nearly 400 papers and identified just south of 200 high-quality papers to inform a final report.

The committee reached consensus that a four-domain model best provided a combination of utility, simplicity, and accuracy in identifying and covering the main components of telemedicine. Those four domains are simple to imagine: access to care; financial impact and cost; patient experience and provider experience; and effectiveness.

The central principle of the framework was that the use of various telemedicine modalities provides health-care services to those who may not otherwise receive them in a timely and effective manner. Once again, telemedicine was felt not to represent a different type of health care but just rather a different method of health-care delivery that provides services that are similar in scope and outcome or supplemental to those provided during an in-person encounter.

The committee identified six key-measure concepts. One of these, actionable information, warrants specific attention.

As a physician, I am receiving and gathering information from patients to make decisions about what they need to have completed. After a complete evaluation in the emergency department, I might not know their diagnosis. I might actually need another test, some imaging, some labs, or a consult. The same is true in the outpatient office setting. The same is true in urgent care. The same is true in telemedicine. The most important thing is not do I get the diagnosis right when I see the patient; it's, do I have enough actionable information to take the right next step so that ultimately we'll get the diagnosis right.

The most appropriate comparison of telemedicine is therefore what the patient would have had available to them, not just an in-person visit. So we know there's an access problem. So for some patients, they have nothing available to them. So to compare telemedicine to an inpatient visit is problematic, because they have nothing or telemedicine.

For other people, they may have different types of in-person visits, and an in-person visit is not the same. You could have a smart doctor or a not very smart doctor, right? You could be in the emergency department that has access to everything or you could be in a primary-care office that doesn't have access to radiology and labs. So you need to compare it to the right

actionable information.

For some patients, like I said, it's no care at all, maybe due to access, but also now with more high-deductible plans, maybe it's due to fear of spending money and they'll sit at home and not get care.

The standard of care should be defined by the medical issue, the provider, and whether or not the appropriate care was delivered, not by whether it was done "in person."

Telemedicine provides different and actually sometimes enhanced information. I do telemedicine. Sometimes I have the advantage of seeing the patient in their home. If a patient calls me with asthma, I might find a really dusty home with four kittens running around. When I see them in their office, they look nice and neat with makeup on, well coifed, and I don't get that information.

And I have gone around and asked my colleagues, who asks "How dusty is your home?" I can't find a single pulmonologist, asthma specialist, a primary-care provider that ever admits to asking that question. So it's different information that gets me to the right actionable information and might actually result in better treatment.

Telemedicine delivers high-quality care while reducing utilization and costs. Studies show that not only

can we meet the needs of our patient, but we can do so in a cost-effective way.

There is a list of studies in front of you. I will summarize some of them to make the point that it clearly has been shown.

One example. In Pennsylvania, it's a 5-percent decrease in annual costly ER visits. A Towers Watson study says 6 billion in savings. And *Issue Brief* by America's Health Insurance Plans estimates $6 billion in savings or more annually.

Reducing transfers has been shown to potentially save $3,000 to $5,000 in some ED-related costs.

A fiscal analysis by other States -- in this particular case, the Maryland General Assembly's Department of Legislative Services -- noted that telemedicine can reduce overall costs due to better management of chronic disease, reduce inpatient hospitalization, and lower transportation costs. This has been shown to be true both in Medicare plans and commercial plans.

In our own JeffConnect program where we do some direct-to-consumer care as well, we know that 83 percent of patients that called us on their phone or computer would have sought care elsewhere, and about half of them would have gone to a more expensive emergency department or urgent-care center.

Our patient satisfaction is through the roof, way higher than we see in our primary-care offices, and we have demonstrated cost savings, even taking into account those patients that need to be referred somewhere and the small percentage of patients that might have done nothing had telemedicine not been available.

In other analyses, legislative staff in Vermont and Maryland have found that any small increase in health-care utilization, because telemedicine is, quote, "easier," is more than offset by cost savings. The same is true in studies from Colorado, Kentucky, and Texas.

The same is true at Jefferson, where we have done our own analysis of our own employees, and we now pay for telemedicine outside of our TPA for our 40,000 employees because we find it so useful to decrease costs.

An important component of Senate Bill 780 is the required insurer reimbursement of care delivered through telemedicine if that same health care is reimbursed when delivered in person.

As we heard from Chairman Mustio, many other States and the District of Columbia already have laws for payment of telemedicine, and many have laws for reimbursement.

Even CMS has sent a clear message that it doesn't think the status quo is good enough. In the recently

proposed physician fee schedule that was open for comments until this week, CMS acknowledges that the statute that limits payment for telemedicine, which restricts where patients can be and what modalities can be used, doesn't fully address what the public has come to expect in their health care.

As a result, CMS proposed creating new services that won't be dictated by existing statute. Kind of if the Medicare Program has gotten progressive enough to change to accommodate telemedicine, we should expect the same of our private-sector partners.

To be clear, telemedicine is reimbursed by some insurers some of the time. Hospitals and health systems contract with a multitude of payers who have a multitude of plans. Although some -- and you got some of them in your reading packet, is my understanding. Although some insurers offer telemedicine services, few offer patients the opportunity to receive appropriate telemedicine from most of their own physicians.

Insurers may offer only primary care. They may offer only behavioral health. They may offer it only through Teladoc or the American Well provider network. So you can see a doctor, but not one who has access to your medical records who can coordinate your care. But they don't pay for it if you're going to see your own doctor.

The inconsistency of payment by the insurers is one of the main arguments for a telemedicine reimbursement law.

With this Senate bill, I will point out that appropriate protections are already in place.

There are unfounded concerns about telemedicine. It's not a new type of care; it's just a delivery mechanism. There are already protections in place to ensure appropriate care is provided, whether it be through telemedicine or in person.

State licensing boards, a medical code of ethics, crimes codes, insurance fraud laws, are not altered by this Senate bill.

So in summary, despite the fact that no other country spends what the United States spends on health care, access to care remains an issue. Pennsylvania's hospital providers and patients believe geography and logistics should not limit a patient's ability to seek care.

Telemedicine is an important tool in the delivery of health care and will increase Pennsylvanians' access to specialized care, save time and costs, and decrease unnecessary readmissions.

Before closing, I want to repeat the five points I made in my opening:

- Telemedicine is one type of care delivery mechanism that can be utilized for some patients some of the time to provide high-quality care;
- Telemedicine positively impacts cost, access, experience, and effectiveness of care;
- Despite complaints about the rising cost of care, patients in the Commonwealth are being deprived of a lower cost option;
- The existing protections are already in place; and
- Care rendered through telemedicine technology should not be held to a different or higher standard of care than care rendered through other modalities.

My final comments in closing are, our primary obligation is to provide quality care. I think we can all agree that it doesn't matter whether that care is provided on the third floor or the fifth floor of a medical complex. It doesn't matter which electronic medical record it is documenting it in, whether it be Cerner or Epic. It doesn't matter whether the physician is wearing glasses, contact lenses, or no glasses. It doesn't matter whether the patient lives nearby or far away. Similarly, it should

not matter whether that care was rendered by telemedicine or in person. Quality care is simply quality care.

Thank you for your time today. If there is time left, I'll be happy to answer any questions you would have.

MAJORITY CHAIRMAN MUSTIO: Mr. Hollander, are you able to stay for the entire hearing or do you have a time limitation?

DR. HOLLANDER: I can stay for the entire hearing.

MAJORITY CHAIRMAN MUSTIO: The reason I ask that, we're going to do things a little bit differently than we normally do. We're going to have everybody testify, and then we're going to have the providers and insurance and integrated systems come up together so that we can ask questions.

What happens a lot of times at these hearings is, you'll have a group testify, and you'll have the other group behind them going, no, that's not right. And then when that group comes up, they'll be able to rebut, because they're second, what was said, but then you have the other group that isn't there, and they'll be going, no, that's not right.

DR. HOLLANDER: They'd do that to me? Because I didn't say it.

(Laughing.)

MAJORITY CHAIRMAN MUSTIO: I think you'll hear that answer on some of the other panels.

DR. HOLLANDER: Okay.

MAJORITY CHAIRMAN MUSTIO: So if you're able to accommodate that, that will -- Members?

REPRESENTATIVE CHRISTIANA: May I say something?

MAJORITY CHAIRMAN MUSTIO: Yes; yes. Representative Christiana.

REPRESENTATIVE CHRISTIANA: Thank you.

I just wanted to point something out to our seated audience, specifically the young, healthy males that are seated so comfortably, that there are six ladies that are forced to be standing in the background. And I know you don't have eyes in the back of your head, but if some young, healthy gentleman would at least offer to stand.

Thank you, Mr. Chairman.

MAJORITY CHAIRMAN MUSTIO: Thank you for being so gallant.

PANEL I:

BEHAVIORAL HEALTH

MAJORITY CHAIRMAN MUSTIO: All right. At this time, I would like to ask Superintendent Patricia Cross to come forward.

Before the Superintendent speaks, you'll notice on the agenda that the title says "Behavioral Health Panel." I had asked as part of the process, as you will see in my time line, I had some conversations with some behavioral health providers from insurers. The insurers would not let them testify today. So I took good notes when I was on the conference call with them, so I just want to read into the record my notes from July 26th. This has to do with behavioral health:

"Do they use just psychiatrists?"

"No, anyone licensed or credentialed."

"Is the objective to increase access using HIPAA approved technology?"

"Yes. It's not a special program. It's the exact same benefit as if they walked in in person. Reimbursement is at the same rate as in person." In other words, it's payment parity, which this bill does not say has to happen. "Commercial members can connect from home," so there's no need for the patient to go to a facility."

Many times with behavioral health, there's that stigma of being seen walking into a facility. So in this particular case, the insurer has the ability to have the individual either on their computer or on their phone getting that treatment, which was astounding. I mean, it was -- and the insurer was so excited.

And I said, how about utilization, because that's a big issue you'll hear, is it's going to be overutilized. The floodgates are going to open and all this type of stuff. And it's like, we have trouble getting people to use it; we have to do marketing.

So that was one of the reasons I wanted them to come today, was because it gave them a platform to talk about how important this type of care being delivered via telemedicine is.

And what was really interesting was, utilization remains quite low, but what happens is, it increases their mental health. So then they are able to go out and exercise and they're not sleeping all day, and their other health, like diabetes and heart disease, improves.

So it's that message that I thought would be important for Members to hear, and I'm glad that I took good notes and I'm able to relay that information to you today.

Now, Superintendent Cross, we haven't met before, but I came across your name by a colleague that you had attended an event, and you have implemented some programs that many schools apparently are starting to do across the State. And you were so excited about it that I thought, what the heck, let's give her an opportunity to present, something you have never done before. So we're -- many of

us had our first time, too. So please feel free to address the Committee.

MS. CROSS: Thank you very much for having me here today, and it's nice to know that chivalry still is alive. It is in the schools as well. And I did enjoy your opening remarks, so.

MAJORITY CHAIRMAN MUSTIO: Thank you.

MS. CROSS: Again, I am the Superintendent of Sullivan County School District.

In September of 2017, Sullivan County School District secured a community and school-based behavioral health program, and it is a behavior program that is set up for our kids that have possibly mental issues.

But before I go into why I think that telemedicine is extremely important, especially within the school districts and especially in rural school districts, let me tell you a little bit about Sullivan County for those that don't know where we are.

We are sandwiched between Lycoming County and Bradford County and Wyoming County. Sullivan County School District is a school that encompasses all of the kids that live in Sullivan County. So it's 454 square miles with 624 kids, kindergarten through 12th grade. So we are a very small school district with very limited resources.

A third of our county is State forests, so we can't touch a lot of that area.

The reason why we are excited about telemedicine, there are limited resources within the county for our families. Families must travel to the neighboring counties, Bradford and Lycoming County, which are approximately 45 minutes to up to an hour for these families away. This includes behavior agencies as well as medical and psychiatric services.

Rural areas may have a smaller patient count; therefore, having telepsych would make it more beneficial for a therapist that otherwise may sit in an office and have no clients, which is what happens in Sullivan County.

So what is a community and school-based behavior program? It's a comprehensive approach to supporting youth and families with services that are accessible, integrated, and comprehensive and coordinated through a single team that provides full clinical interventions and responsibilities without fragmentation:

- It is based in the schools, with services provided in the school setting as well as in the community and home settings, where students can meet with the team through a push-in and push-out classroom approach.

- If families will not come to the school to meet with our clinicians, they will go to the home. That's how responsive it is.
- Youth and families receive varying intensity of services.
- The program operates year-round, providing services in the school and the community in the summer to our youth.
- CSBBH is a single point of contact for behavioral health.
- Our team identify co-occurring mental health and substance abuse disorders and needed interventions.
- They coordinate family and student with medical providers.
- Sullivan County currently has a three-member team. One of those has a master's degree, two bachelors or master-level clinicians with at least 2 years of behavior experience with children and adolescents, and we have a team consultant that comes and visits 4 hours a week.

We are set up to have telepsych come into the school, which is very exciting, and we're one of the first.

In fact, we're one of the first in Bradford and Sullivan County to have the mental health school-based program.

Sullivan County is a school district that is very fortunate to have a community and school-based program in our schools. The school-based team has, currently, 14 students on the caseload. Seven of those students are in the process of being seen through the use of telepsychiatry.

How are our students identified for this process?

- The mental health professional puts together a medication management request that is submitted to the nurse for review.
- The nurse may or may not request medical tests depending on what's indicated on the child's chart.
- The CSBBH team would work with the family to ensure all processes are completed.
- The nurse then reviews all the information and then speaks with the psychiatrist to discuss who is going to be seen.
- A parent and a guardian must be present with the child for a session with the doctor and a nurse. An LPN is always there.

- Our mental health professional team is in the room as well with the parent and the student.

Insurances that cover these services, there's only two: HealthChoices and Magellan. If our students cannot or do not have those types of insurances, then the team does everything they can do to help with the financial need.

The community and school-based behavioral program's definitive purpose is being a single point of contact for behavioral health for students and their families that is based in the school. Meetings, assessments, and interventions take place on school grounds. If families are unable to come to the school, the team visits their homes. Families do not have to travel to three or four, up to five different agencies that are a minimal 45 minutes to an hour, some even 90 minutes away, for their children that so desperately need the help.

Telepsych services allow the school and the providers to:

- Address and meet students' mental health needs quicker. Without these services, students would go through the entire process within the school and then be lost because the families

would not or could not drive the distance to have time to visit the medical providers.

- Our team also facilitates the required psychiatric and psychiatrist for the success of the students helped by the program.
- They eliminate the stigma that could be associated with mental health. It allows a family to stay in the familiar surroundings of the school to meet with the psychiatrist.
- It provides comfort. Students and families are very comfortable with the telepsych and speaking with the doctor in this type of venue. It's less intrusive, it's economical for families, and it provides the comfort of a familiar environment when they are in crisis mode. As much as they might not like school, at this time, they do like the school setting.
- It keeps -- and something I'm very excited about -- it keeps absenteeism down. If a child has to travel 90 minutes to see these services, they're missing school that day. Now they're only missing it for approximately an hour, an hour and a half, and can go right back into the classroom.

- It also keeps the team members there at the school, so if there is any other crisis happening, our team can respond to it immediately instead of being away, driving our students to these services.

Most recently, you all know that school safety is of the utmost importance, and the issue of school safety is a tremendously important topic that currently has many State lawmakers gathering and discussing concerns, looking for appropriate solutions.

Highlights from the *School Safety Task Force Report 2018* was released to school districts in June. The *School Safety Task Force Report* emphasizes five areas that they would like to see addressed: communication and information sharing, training, mental health services, emotional and social learning, and strengthening building security.

In a report released August 27th, the Attorney General stated that he supports and continues to emphasize the need for more mental health support in schools. I support that statement that enhancing mental health programs that could be used for identifying students who possess dangers is one step towards increasing safety.

We are one step ahead of that, because we do have the mental health program in our schools, and we do have telepsych where our kids can be addressed and helped.

In my opinion, you can't go wrong with telepsych or telemedication. Our county has recently gone through an intensive study, which I have attached to my report, where they are now a pilot program within the county and are starting to use their telepsych and telemed in their small, small medical facility. It's a very small medical building.

So I'll be happy to answer any questions that you have. My testimony, hopefully maybe I caught up on some time that you lost. But it's just very simple. It works. It's great for our kids, and it's important to have it for the safety and well-being of our students and families.

Thank you.

MAJORITY CHAIRMAN MUSTIO: I want to thank you for coming and testifying on short notice, and you can tell your students that you got an A-plus.

MS. CROSS: Thank you.

PANEL II:

PROVIDERS

MAJORITY CHAIRMAN MUSTIO: Okay. We're going to

move into the provider panel. If those members on the panel would please come forward: David Hall, Ann Huffenberger, Liz Deleener, Dr. Desai, Dr. Caicedo -- help me with some of these, please -- Dr. Saiyed, and Dr. Bean.

Now, Members, as we go into these next three panels, I think that it's important for us to consider these questions. And we have seen it in some of the testimony that has been emailed to us where insurance companies say they are already paying for telemedicine and they have embraced telemedicine:

Insurance companies are providing care via telemedicine. Is that the same as paying for it in person?

Is that what we saw in demonstrations?

Is this issue about control or access to care?

Is this issue about control or reducing costs?

When insurance companies say they encourage and cover telemedicine now, what does that mean?

How does that statement coincide with what we saw at the demonstrations across the State and those coverage sheets in your binders?

Is this an insurance mandate -- is this a mandate on insurance companies as they state, or is it really a prohibition on payment avoidance and a prohibition on restricting access of care?

And I think that's what we need to start to digest as we listen to the testimony, because both sides make valid points and sometimes there is talking past each other.

And it's our responsibility to determine if the legislation as written needs to be tweaked and if the suggestions that have been made, and just for Members' education, there is some suggested language. LRB has not gotten it back to us in draft form yet because we wanted to have this hearing first in order to determine if the suggested changes that we are recommending are enough.

So with that being said, I guess we'll go in order as on the agenda. David Hall, would you please start.

And I would ask you to please refrain from using acronyms, SOAP or, you know, the EMR or whatever. Say it first before you start to abbreviate it or you'll lose all of us.

MR. HALL: I'll try.

MAJORITY CHAIRMAN MUSTIO: Thank you. And please make sure the microphone is on.

MR. HALL: Thank you.

So I'll go ahead and give my brief statement. It is very short, and I'll kind of just highlight some of the key pieces of it.

So Guthrie actually supports Sullivan County, as we just heard. They support five counties in Pennsylvania, targeting about 4,000 square miles, including Bradford, Tioga, Sullivan, Susquehanna, and Wyoming.

So our rurality of those counties, the lowest percentage is 72, upwards of 100 percent. So we really embody the idea of rural telemedicine. We need telecommunications technology to take care of our patients.

Those that we represent really are the working farms, the mines and quarries, the lumber mills. Those are the patients that we represent, and those are the patients that we need to see. They don't always have reliable transportation. A lot of times they may be an hour and a half away from the closest primary-care center. We need to have options, urgent-care options, so we don't end up, these patients, progressing into chronic conditions and ultimately being hospitalized.

Really, a lot of our strategy -- so we're not a large health system. I would say we're a medium-sized health system: four hospitals, three of them in Pennsylvania, one being a critical-access hospital in Troy, Pennsylvania.

Our strategy for telemedicine really should be focused on providing the most effective care to our patients and targeting populations with the greatest risk,

including chronic conditions in the post-acute population.

But currently, we're constrained, so we are constrained by geographic boundaries that are set by payer regulations. We are set by policies that must be met prior to approving visits with patients. We are bound to the payer's requirements before we can focus on our true strategy of actually addressing the patient's needs first.

Really, I want to highlight a couple, four things that we find telemedicine, really the foundation of telemedicine for us and the benefits.

So one being better access, more consistent engagement:

We're struggling with an aging population and an extreme shortage of physicians across the country. Ease of access would allow patients to get the care they need, regardless of location. A patient could have a visit with an oncologist on a rare form of cancer or see a genetic counselor 300 miles away.

This would also allow patients to see their specialists more often, driving patient engagement in their own conditions, creating a stronger doctor-patient relationship. We can better prepare and empower patients to manage their own conditions.

Two is better quality of care:

So the ability for a provider to follow up with

their patients in a timely manner directly correlates with better outcomes.

The focus on preventative medicine to include remote monitoring for those with chronic conditions can help to decrease mortality rates for conditions that can be treated and managed.

For certain specialties, such as behavioral health, telemedicine actually provides a superior product with greater outcomes and patient satisfaction; i.e., access. We don't have access to behavioral health right now. We do have a means to create access, though.

Number three, patient demand and satisfaction:

So numerous studies showing an increased patient demand in the adoption of telemedicine. As physician shortages grow, we will see the demand for telemedicine services increase.

So at the end of my statement, I polled two questions. We poll every one of our patients at the end of their visit, their virtual or telemedicine visit, and one of the questions that we ask is, what would you have done if we did not offer this service? And one of the responses, and actually a very popular response is, I wouldn't have seen the doctor, you know, and that's what we want to avoid. As we move into preventative care and we reduce the need for just treating the chronic condition, we

want to prevent the chronic condition. So we want to increase patients seeing their primary care regularly.

And then number four, health cost savings:

So funding and adopting telemedicine technologies directly reduce and contain rampaging costs for health care, reduce travel times, fewer and shorter hospital stays, automation of administrative roles to improve efficiency.

Right now, administration represents 31 percent of a physician practice. We could automate some of those roles, reducing the need for overhead expenses.

So that's really the highlights of my statement. You know, I think telemedicine is fantastic technology. It has actually been around since 1929 -- or 1925; I'm sorry -- Hugo Gernsback. So if none of you have heard his name before, he was actually a sci-fi writer back in the early 1900s.

He started the idea of telemedicine where a physician would be on one side and a robot would be on the other side with the patient, with robotic arms that he could control and he could touch the patient and see the patient and he could communicate with the patient. Little did we know in, you know, 80 years, you know, Hugo was pretty close to what should be the next norm.

That's it.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Ann Huffenberger?

MS. HUFFENBERGER: Yes.

MAJORITY CHAIRMAN MUSTIO: Please turn the microphone on. Thank you, Ann.

MS. HUFFENBERGER: Good morning, Chairman Mustio, Chairman Readshaw, and Members of the Committee.

My name is Ann Huffenberger. I am a registered nurse for over 30 years, and I serve as the Director for the Penn Medicine Center for Connected Care.

I would like to thank the Committee for allowing me to provide testimony on Senate Bill 780, which would authorize the regulation of telemedicine by the professional licensing boards as well as provide insurance coverage for care delivered by telemedicine.

I'm going to speak a little bit about Penn Medicine and how we're approaching this new frontier.

For Penn Medicine, telemedicine is utilized as a method of care delivery to enhance access to high-quality services that promote the well-being of our patients and our communities.

We utilize telemedicine to reduce morbidity and mortality, unplanned readmissions, and avoidable emergency department visits, thereby fostering the appropriate utilization of our health system.

Our telemedicine use cases include intensive care, stroke care, trauma-obstetrics care, on-demand primary care, low-risk specialty care, registered nurse case management care, and remote patient monitoring as well as other virtual-care programs. These use cases, specifically in the area of remote patient monitoring, have demonstrated to us that families and patients are embracing the technology to better manage their chronic illness. This results in superior outcomes as well as lower health-care costs.

Use cases, as others have mentioned, over the years have increased as networks and network devices have transformed the way that we connect to our patients. At Penn Medicine, as we actively transition from fee-for-service to value-based models of care, we expect telemedicine will become more mainstream, promoting provider-to-provider collaboration as well as allowing patients to receive high-quality, cost-effective virtual care wherever and whenever "hands-on" care is deemed not clinically essential.

Furthermore, as others have highlighted, there is an emerging body of evidence demonstrating the beneficial outcomes of telemedicine. Our researchers have affirmed outcomes that include reduced morbidity, mortality, and length of stay with our telemedicine intensive care as well

as our telemedicine stroke care, reduced readmissions in chronically ill patients with our remote patient monitoring, and reduced utilization of the emergency department visits as well as urgent-care centers with our on-demand virtual primary care.

It's important to note that our researchers have also demonstrated enhanced patient-family satisfaction, and this is associated with the convenience and cost-effectiveness of telemedicine.

At Penn Medicine, our telemedicine includes real-time audio-video visits, which include the transmission of protected health information, radiological images, and physiological data.

Our audio-video visits are conducted within the envelope of our electronic medical record and, therefore, are inherently secure. In all cases, our telemedicine visits are considered to be the equivalent of our inpatient visits and, therefore, subject to the requirements of HIPAA.

As technology evolves and availability increases, telemedicine will play an increasingly large role in supporting health-care needs across the Commonwealth. Connected Health, particularly in partnership with our rural hospitals, will be effective in supporting four important areas:

- First, we will continue to expand the utilization of telemedicine in clinically appropriate use cases to provide high-quality, cost-effective health care that improves the well-being of our patients and our communities.
- Next, telemedicine will promote access to specialty care from highly specialized providers who manage rarer conditions such as bone marrow and organ transplant as well as complex heart, vascular, cancer, and neurological conditions. Smaller health systems often endure operational challenges in providing these specialties, and therefore, these services tend to concentrate in academic settings.
- Third, we believe telemedicine will provide supplemental clinical services in rural areas where provider shortages are occurring. We have seen and experienced these challenges in mental health, genetics and genetic counseling, stroke neurology, nutrition, palliative care, and social work.
- And last, we expect that telemedicine services such as telestroke, teleneurology, tele-ICU,

and other virtual specialty-care visits will prove useful in providing real-time second opinions in situations where timing is crucial.

Each of these telemedicine visit paradigms promote value by providing patients with the right care, at the right time, in the right place.

Penn Medicine supports Senate Bill 780 because it will continue to promote the expansion of telemedicine services that improve access to high-quality, cost-effective care to our patients and our communities.

I thank the Committee for allowing me to testify today and will also be available for questions should they arise.

Thank you.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Liz, do you need to testify or you're just---

MS. DELEENER: I'm okay.

MAJORITY CHAIRMAN MUSTIO: You're okay? Okay.

Dr. Desai. Am I pronouncing that correctly, sir?

DR. DESAI: Thank you. Yes; Desai.

MAJORITY CHAIRMAN MUSTIO: From Children's Hospital of Philadelphia. Thank you.

DR. DESAI: Good morning.

My name is Bimal Desai, and I serve as the Assistant Vice President and Chief Health Informatics Officer at the Children's Hospital of Philadelphia.

I oversee the programs in digital health, which includes telemedicine, analytics, and clinical informatics. I am also a practicing general pediatrician. I have served at CHOP for the past 18 years, and I care for hospitalized children on the general pediatrics inpatient service.

First, on behalf of the Children's Hospital of Philadelphia, I want to thank Chairman Mustio, Chairman Readshaw, and the Members of this Committee for having a hearing on this important issue and allowing me to testify.

I'd also like to thank Senator Vogel and Representative Quinn for their leadership on this legislation.

So the bulk of my testimony will focus on how telemedicine and this legislation specifically will help to expand and improve health-care delivery in Pennsylvania, especially for our more underserved populations. I plan on providing you real-life examples of some of our different programs at CHOP.

One critical piece of this legislation is the notion of "coverage parity," which is the requirement of a payer to provide coverage for telemedicine services in

every circumstance where the same service is also covered as a face-to-face encounter. And simply stated, this section of the legislation ensures that physicians and health-care providers who offer telemedicine care as an adjunct or alternative to face-to-face care will be compensated for their clinical work.

Coverage parity also provides protections for consumers and assurances for health-care providers, reducing denials of claims and out-of-pocket expenses for patients. Today -- and I think Dr. Hollander alluded to this -- because insurers cover some types of visits in some settings in some conditions and not others, it is very challenging to create a comprehensive telemedicine program that benefits all patients. Both in our State and nationally, this lack of coverage parity has hindered the adoption of telemedicine.

Of note, this legislation does not mandate "reimbursement parity" for telemedicine, and we recognize that reimbursement should be commensurate with the complexity and the extent of the care that is provided.

But there are many ways that telemedicine can benefit Pennsylvanians:

First, we believe that telemedicine is more patient centered. We tend to overlook that the cost of an illness includes not just the direct medical expenses but

the indirect cost to society. So consider something as simple as pediatric ear infections, the most common cause for antibiotics in the pediatric population.

In the United States, the annual burden of just that disease is $3 to $5 billion, and shockingly, 90 percent of that cost is indirect. It's the cost of the parents missing work. It's the cost of children being out of school, the cost of travel back and forth. And I think that's a cost that is overlooked in many of these discussions.

A truly patient centered health-care delivery model would allow families to seek care in a way that does not jeopardize employment, that minimizes school absenteeism, and reduces time spent in travel. Telemedicine can help to accomplish all of those goals.

From our own data at CHOP, we know that telemedicine visits for patients who have had knee surgery saved an average of a hundred miles of driving, 50 miles in each direction. That could easily be the difference between having to miss a day of work or not.

No Pennsylvanian should have to risk their employment, pull their child out of school for an entire day, and then spend the day fighting traffic on the interstate just to receive care that could just as easily be provided by telemedicine. Where we can ensure that a

telemedicine offering is clinically equivalent to face-to-face care, we should give patients that opportunity to choose telemedicine.

Second, telemedicine is more equitable. We know that the distance that patients must travel by itself is a risk factor associated with your health outcomes. So the further you live from the site of care, the worse your outcomes are for a variety of conditions.

But telemedicine offers a way to bridge this inequality. A recent Pew Research Center survey on Internet usage showed that 77 percent of Americans have smartphones, and between 80 and 98 percent of Americans have Internet access, and those numbers continue to climb every single year. For the vast majority of Pennsylvanians, that means that your mobile phone or your home Internet connection has the potential to directly improve your access to health care through telemedicine, regardless of where you live.

A number of clinical programs at CHOP could benefit from telemedicine, allowing us to offer patients who travel long distances the same standard of care that we offer to those who live nearby.

Imagine a child with terminal cancer receiving palliative care from the skilled doctors and nurses at CHOP. Today, our palliative-care team will and does drive

to the child's home, but there is a practical limit to this. We often will only drive up to an hour to see these families, because the travel costs, the travel time, becomes prohibitive. Because of that travel time, by definition, patients who live in the Poconos cannot benefit from this same standard of palliative care as patients who live in Paoli. And it limits how families can interact with the palliative-care providers at these critical moments toward the end of their children's lives, and I believe our families deserve better.

In another example, through a unique partnership with the city of Philadelphia, we provide evaluation for children who are victims of child abuse and neglect at a clinic in North Philadelphia. With one pediatric child-abuse fellow on-site using a high-definition scope and one attending physician offering remote consultation from CHOP via video, we can ensure that these children receive the same high standard of care that we offer on our own campus.

Overnight, when a child-abuse specialist may not be in the hospital, we use the same telemedicine technology to provide consultation to the CHOP emergency department, so that regardless of the time of day, every child who is a suspected victim of child abuse receives the same high-quality evaluation and documentation of their physical

findings. We simply could not offer this service as consistently or at the scale that we do without telemedicine.

Third, telemedicine is more timely. Many studies have shown that for clinical conditions where minutes matter, literally minutes, like adult stroke care, a remote assessment by a specialist can be effective as part of the triage and diagnosis process. As part of the teleconsultation program between our CHOP-based neonatologists and the CHOP transport team, just this past Sunday night we were able to help the team at a referring hospital stabilize a very, very sick infant to allow for safe transportation to CHOP.

As another example, we are taking steps to address the high demand for pediatric dermatologists in our region. As it turns out, a number of common pediatric dermatologic conditions can be effectively triaged or diagnosed using a high-def image, the kind that your typical smartphone can easily take these days. That's why we are developing a teledermatology mobile application at CHOP, where parents can securely capture and transmit the pictures of their child's rash and get a diagnosis and a treatment recommendation within a day -- not a week, not a month.

Fourth, telemedicine is cost-effective. Research

has shown that care coordination and care-management strategies that use telemedicine offer high value. As a very basic principle, if a standard of care can safely be provided at home, that approach is always better for the patient than care provided in a hospital setting.

In a landmark study, researchers in Europe showed that a program of home weight-and-caloric monitoring using a simple iPad application and twice weekly telemedicine visits shortened NICU, neonatal intensive care unit, length of stay by a staggering 22 days.

Our own neonatology telemedicine program started in 2016. Our neonatologists observed that 50 percent of NICU graduates come back to the emergency department within 3 months, and 30 percent were readmitted to the hospital.

We also noticed that the first 2 weeks that the child is home are particularly risky, and for the parents of a sick infant who has just "graduated" from the neonatal intensive care unit, going from the near constant surveillance provided in the NICU to the home setting where you have very little, if no support, can be a terrifying prospect.

In response to this, we started the CATCH program, which uses telemedicine to help transition complex NICU patients to the home setting, and the early outcomes of the CATCH program are promising. Nearly half the time,

the video visits provide information that would have been missed by a phone call alone. Half the time, parents report that telemedicine visits prevented additional calls or visits to a medical provider. And in four of these visits, the CATCH team was able to identify that a child needed to be admitted to the hospital sooner, allowing for a controlled admission instead of an emergency visit occurring after the patient had already begun to decompensate at home.

CHOP is actively developing population health and care-management strategies to facilitate earlier discharge from the hospital and to keep patients healthier at home, and we envision telemedicine will be a part of this approach.

As the technology matures, we also think there's a role for remote monitoring of our sickest patients, and you have heard examples of how many health systems are already doing this. We need a robust telemedicine infrastructure to support these programs so that we can be better stewards of health-care resources and provide the highest value care to our patients.

Fifth, telemedicine is safe and effective. Referencing the same study that Dr. Hollander referenced, in 2016, the Agency for Healthcare Research and Quality looked at nearly 1,500 published studies of telemedicine

and concluded that telehealth interventions worked for patient monitoring, chronic disease management, and psychotherapy. Through better communication and care coordination, telemedicine was associated with reduced mortality, improved quality of life, and reduced hospital admissions.

Of course, not every visit is appropriate for telemedicine, and that's not the goal of this bill. Health systems already successfully deal with the limitations offered by different care modalities. Our systems already acknowledge that an emergency room is not the right place to go for routine care, that the primary-care office is not where you should go for surgery, and the surgical clinic isn't the best place to show up when you have the flu.

In the same way, we acknowledge you can't fix a fracture via telemedicine, at least not today, but you can assess a recent surgical site to see if it's infected, you can assess that a patient with asthma is in respiratory distress, and you can coordinate the care of a medically complex child. This bill is about how we can use telemedicine to support high-quality, lower cost care for all Pennsylvanians.

Finally, I wish to leave you with a story of our partnership with the Norristown Area School District, a program which was featured in a recent op-ed in the

Philadelphia Inquirer and which has also garnered attention from the Children's Hospital Association and American Academy of Pediatrics.

Through this program, we allow school nurses to receive live consultation from a CHOP pediatrician using a novel telemedicine platform, and our goals are to:

- Increase access to care for sick kids in order to potentially reduce the severity of an illness by catching it early; and
- To reduce the utilization of urgent-care centers and emergency departments for lower acuity care.

Regarding this last goal, this is a quote from the parent of a child seen by the school telehealth program:

"[The telemedicine visit] was a big help. I was really busy at work -- it would have been hard for me to leave. It was late on a Friday afternoon, so getting a doctor's appointment would have been difficult. Maybe we would have been heading to an urgent care" center "over the weekend. But this was perfect!"

Currently deployed at 3 schools in the district, we are expanding the program to 12 schools this year.

Members of my team, in fact, are attending the district's parent Open House events tonight to answer questions that parents may have and to demonstrate how the video visits work.

And this is not an ordinary teleconference or a video visit. We provide the Norristown school nurses with a state-of-the-art device that fits in the palm of your hand, complete with interchangeable exam instruments like a snap-on stethoscope and tongue depressor. The device allows a remote provider to see the child's throat and eardrums, to hear amplified heart and breath sounds, and this all happens at the same time as the nurse is conducting the exam.

These interactions with our experienced CHOP providers can help to coach school nurses and keep them updated on the latest common pediatric treatments. In addition, this program creates an important longstanding partnership with school districts, nurses, and families.

The next frontier for this partnership is to expand the services we offer to provide much needed telebehavioral health to children, as you have heard earlier today in the testimony. We will use a validated screening tool designed to identify students who are struggling with mental health issues so that they can receive intervention sooner.

Why is this so important? Well, we know that among adolescents age 13 to 18, one in two will have a diagnosable mental health condition at some point, and one in five will exhibit severe impairment as a result of that. This is according to the National Institutes of Health. When offered via telehealth, children are more likely to get the mental health services they need.

And consider what this represents for our State. Through this program, children at risk for depression, suicidality, anxiety, and behavioral outbursts can receive the mental health screening and counseling they deserve via telemedicine before a mental health crisis manifests.

While this kind of telehealth program may be new to Pennsylvania, it's being used successfully in many States, including New York, Florida, and Texas. Children in Pennsylvania deserve this same robust access to mental health services. Furthermore, by being more aggressive with screening and preventative health care, we believe we can intervene before the child presents in crisis to the emergency room.

I believe that the passage of this legislation would represent a critical moment for Pennsylvanians. Whether your town has 2,000, 20,000, or 200,000 residents, you deserve the same access to safe, effective, patient-centered, equitable, timely, and cost-effective

telemedicine.

The degree to which hospitals and health systems can offer and successfully implement these programs hinges on the coverage parity outlined in this bill. As a physician, as a health technologist, as a cost-conscious patient, and most importantly as a parent, I hope you will support this bill.

I would like to thank you, Chairman Mustio, Minority Chairman Readshaw, and the Members of the Committee again for this opportunity to testify and to share our vision of telemedicine at the Children's Hospital of Philadelphia.

Thank you.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Dr. Caicedo? Am I -- Caicedo. I'm sorry. Thank you.

DR. CAICEDO: Thank you, Chairman Mustio, Chairman Readshaw, and Members of the Professional Licensing Committee.

I appreciate it. My name is Christian Caicedo. I'm Senior VP for UPMC Pinnacle and President for the Cumberland Division.

I know you folks have done some visits to our partners in Pittsburgh, and I'm going to be speaking to some of the experiences and developments that we have had

here in telemedicine right in your backyard in Harrisburg and how that has been enhanced with our partnership in Pittsburgh.

Back in 2009, we started our telehealth program and exploring how we were going to help ourselves. There is a very finite resource called neurologists, and they are the ones that help us diagnose and help us manage our stroke patients. And we had very few of them, and we had lots and lots of patients and lots of counties to cover.

Back then, in 2012, when we started our telestroke program, we just had our two hospitals, Harrisburg and Community General, but we were covering Dauphin, Perry, and Cumberland Counties. And as you know, with the addition of the West Shore Hospital now, we are covering an additional area. And now with our new partnership with CHS and UPMC, now we have eight hospitals and cover seven counties, a total of 283,000 ED visits, and that resource has not gotten any larger.

So we decided that we were going to do telehealth and how we were going to expand and provide that access and services to our community, and we started by helping ourselves. We put the right platform in place. That is protected, dedicated servers, if you would, HIPAA protected, with the right resolution so that a neurologist can see our patients in all of those sites.

That story really took a life of its own, and a lot of other services started looking at the results that we were getting in reducing the amount of time that a neurologist would see a patient and how quickly they can get the right medication so they can get the right therapy. And they started saying, how can we implement this in our own service line?

And it has grown exponentially, actually. We have services in cardiothoracic surgery, congestive heart failure programs that we do actually whole monitoring and seeing patients in remote sites.

We do dentistry out of our emergency department. That's a huge problem and a huge gap right here in central Pennsylvania.

Endocrinology; geriatric medicine. In our long-term-care facilities, we have been able to expand into those services so that people that are leaving from our acute-care facilities are getting the continued care in those facilities.

Infectious disease. Again, another finite resource. Not a lot of these folks around, and I'm going to allude to some examples later on in my talk.

And labor and delivery. I have witnessed at least a handful of deliveries, precipitous deliveries in hospitals and emergency rooms of our own system that don't

have access to an ob-gyn, that having access to that individual, an ER provider can actually be coached and help with the delivery of that patient.

Then you have a neonatologist that will come in on that same call and help the nurse and that physician manage that newborn baby before we can get them packaged and then get them to a labor and delivery unit or a neonatology intensive care unit. That has been very successful, though.

Observation medicine. Primary care has been utilizing this and expanding some of the resources that we have to areas where you would not otherwise have primary care in some of our sites.

Podiatry.

Rheumatology. Incredible. Rheumatologists are hard to come by as well. And, you know, some of the folks, our partners at J.C. Blair and Fulton County Medical Center, don't have access to those. We are providing that in an outpatient basis at no cost.

Stroke neurology, we spoke about.

Transplant services, wound care, and ostomy.

I want to speak a little bit about transplant services, because I think it speaks to a little bit of population health and managing folks out that are highly ill or immune compromised that need to be managed and

monitored after they have had the transplant or previous to it.

These folks, and I can tell you, nationally, 37 percent of readmissions that occur in our hospitals happen because of medication issues. These folks are sent home with an iPad and a secure link to our pharmacists, nutritionists, or transplant coordinators that they can have a regular touch so that these folks are taking their medications correctly. If they have any questions about the regiment that they're following, anything about their wound, anything like that, they can have someone that is readily available to them in real-time video visits so that they can actually have that question answered.

Not only is that very important, but what I'm going to allude to is that, you know, how we speak about -- pardon me -- food deserts. I say that we also have clinical expertise deserts. My colleagues have spoken about psychiatry and other expertise. Our folks at Hershey Medical Center just experienced this. And this is not speaking badly about Hershey, but we're all vulnerable to experts such as MS neurologists of not being accessible to our patients. So 2,100 folks, maybe even folks that are in this room here, did not have access to their multiple sclerosis specialists and were left with a very devastating, complex disease and trying to navigate those

waters on their own. That's very difficult for a patient to go through.

In 14 days, fortunately for us, with our partners at UPMC, Dr. Heyman and Dr. Busis, who are our multiple sclerosis experts, were able to stand up with us, a multiple sclerosis clinic, and we were able to capture and provide those services to the people that were most acutely ill -- continue their infusions, continue their care, and continue to provide those services. We provided a safety net.

Now, fortunately for Hershey, they were able to provide those services, and those patients have gone back. That's fine. But this is a perfect example of how utilizing telehealth and the telemedicine platform, we were able to provide those services to those 2,100 individuals, whether they came to see us or not.

The other thing I would like to allude to is, I know that there is concerns about utilization. If we put this out there, more patients are going to utilize it and the costs are going to go up. And my argument would be, you're right, utilization is going to go up, but it's the right utilization.

As an ER physician, I would much rather have my mother-in-law, who has CHF, to pay or her insurance to pay $100 three times a month than come see me when she's

completely decompensated and pay $1,500 to see me and then $10,000 for the hospital stay so we can get her back to her baseline. So I want utilization to go up; it's just the right utilization, and that's what's important when we're talking about this kind of platform.

Dr. Hollander, I respect him. I have worked with him on the other telehealth issues, and, you know, he talks about the Triple Aim, and I'm all about that. Here's the other person that we're forgetting in this interaction, is the physician. It's actually -- and we have to think about the Quadruple Aim. We need to think about quality. We need to think about costs. We need to think about access and the patient experience, but also the physician.

If we provide this tool for our providers and diminish their windshield time, they could see more people from a bunker, or one site, provide quality services, and it improves the quality of their life. We are losing physicians. We're losing folks because it's becoming harder and harder to practice medicine. This tool will allow them to extend their expertise to more folks and make their quality of life better -- a very important piece.

The other thing our folks, my partners here have spoken about is extending expertise out into rural communities so that we can help stabilize and then get them to the right resource.

The other side of that coin is having expertise that would actually see a child in Guthrie or another facility that doesn't have those expertise and say, no, it's okay, keep them; stay there. We will provide you support via telemedicine, but you can actually keep that child. That's even -- I would say that that's even more important, because keeping people in their community with their doctors, you know, close to home, is just as important as having the access to those expertise in Philadelphia, in central PA, out in Pittsburgh.

Now, here's the other thing why I think it's so important that this bill passes: Today, right now, at this minute, is the slowest rate of innovation that you will ever experience. Let me say that again: Today is the slowest rate of innovation that you are ever going to experience, because in 12 hours, it's going to get faster. Tomorrow, it's going to get faster. This bill will provide us with the skeleton, the foundation, and the guardrails for paying for this type of platform, because in a year when haptic feedback -- and I can explain what that is -- comes into play and is part of telemedicine, then we need to have the foundation of how we're going to pay for that, how we're going to regulate it, and what are the guardrails for it.

Thank you.

MAJORITY CHAIRMAN MUSTIO: Would you say that word again?

DR. CAICEDO: Haptic Feedback.

MAJORITY CHAIRMAN MUSTIO: What does that mean?

DR. CAICEDO: So if you use certain tablets or some vehicles, if you press a button, you get a feedback. You get like a pressure. It pushes back on your finger. So let's say that at some point I'm able to see a patient via my phone, and I say, put the camera next to or put a pad next to your belly, and I'm going to press on it and I'm going to get feedback on my finger of what that belly actually feels like.

It's coming. Let's get ready for it. Thank you.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Dr. Saiyed?

DR. SAIYED: Yes. Thank you, Chairman and the Members of the Committee, for giving us the opportunity to speak.

I'm just going to echo and allude to some of the comments that Dr. Caicedo and my other colleagues have mentioned here.

I'm Salim. I'm a family medicine physician, and I'm going to give more of a perspective from the primary-care side of the things.

We're in central PA. We have a primary-care crisis really here as well as across the country. We cannot recruit enough primary-care docs. Our primary-care clinics are to full capacity. We frequently have patients that cannot get into primary-care clinics because most of those docs are not accepting new patients.

I'll tell you, telemedicine, we've been doing some form of telemedicine for a very long time. We have frequently received patients with chronic conditions such as high blood pressure or diabetes that we require follow-up. We add medicines; we take away medicines; we adjust medicines, and a lot of that can be done by telemedicine.

But currently, we frequently don't get paid for these services. If we did by this legislation, it would definitely help us move and expand some of these services that we currently offer. Instead of having patients come in, we can increase our capacity of primary-care docs and we can see more patients.

One other point, and again, this has been made, is that we want to see more patients but at the right time and the right place. Just like we're trying not to see patients in the ED if they're not sick, it's the same movement towards primary care. We don't want to see those patients in the clinic if we can deliver care using

telemedicine.

And lastly, I can discuss and debate the evidence behind telemedicine all day long. Of course, trying to be time conscious, it is, at the end of the day, about the well-being and the health of our folks, of our people in this State. By this legislation, that's what we're trying to deliver and care for.

Thank you.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Dr. Bean.

DR. BEAN: Good morning, Chairman Mustio. Good morning, Chairman Readshaw and Members of the Committee.

I am Eric Bean. I'm an emergency physician at Lehigh Valley Health Network, which is based in Allentown. I'm also board certified in family practice. So I bring a unique perspective to the table of both someone that works inside of the hospital as well as someone that has some experience outside of the hospital.

It was an honor to host Chairman Mustio and several Members of the Committee, to have them at our hospital to show them some of our technology.

As a physician, I am trained to care for patients and their families. I lead passionate teams of health-care providers, which include our nurses. We work at a teaching hospital, so we're involved in training future physicians

as well as future nurses.

I would like to speak to you today about the importance of the telehealth reimbursement, specifically about all those groups.

In your remarks you will see there are lots of stories from our grateful patients in their own words and their own written statements. They're grateful on many levels. They're grateful to avoid the transportation costs. They're grateful to avoid leaving their own communities where their social support and loved ones live and reside. They're grateful to have increased access to the difficult specialists, the hard-to-find specialists -- the burn surgeons, the intensive care unit physician, the infectious disease specialist, the neurologist, the behavioral health specialist, and I could go on and on.

We, like a lot of my physician colleagues up here, have demonstrated that by offering infectious disease specialists at some of the rural hospitals, we have decreased transfer rates by between 95 to 99 percent. In addition, we lowered the cost of antibiotics that are provided to those patients. So while keeping the patients were they want to be and decreasing costs, we have truly started to meet that Triple Aim.

I want to talk about our nurses. I haven't heard much about our nurses here, but nurses are an important

part of the telehealth piece.

Our ICU nurses have the additional support of a remote ICU team. We have been doing this technology for 14 years. We have a team of three nurses plus an intensive care specialist that are a second set of eyes on every patient at Lehigh Valley Health Network -- 120 beds. These providers have been shown to -- specifically the nurses -- have been shown to add 90 minutes of additional hands-on care from the on-site nurses by offering this additional layer of coverage. That's more patients being cared for better. We have shown decreased mortality; decreased ventilator usage; decreased time in the ICU.

The nurses, as I mentioned, are an active part of this team. They help us assist, as my physicians have talked about, assist us in the exams. We want nurses and give them the abilities to practice to the top of their license, working side by side with physicians.

Really, I see the future of tomorrow is really here today. Kaiser currently does over 50 percent of their health care via telemedicine. Greater than 50 percent is being provided using telemedicine and telehealth technologies.

We talked about the physician shortage. Here are the numbers: 120,000 physician shortage by the year 2030. This is coming and this is going to happen, and we need to

think of ways to which we can meet that demand.

I think most notably of the Veterans Administration and the care that they are providing. They have some serious capacity issues, and what technology are they using to cover that capacity issue? Telemedicine. More than just behavioral health, they're looking at the specialists, et cetera. And I could list several, that they are also trying to offer the capacity to care for our veterans that have served this country.

We're already at a crisis situation with psychiatry. I don't need to belabor the point of where it's not only children, it's adults and it's our seniors alike are all suffering with depression, mental health. Not to mention, let's talk about opioid abuse and substance abuse and how telemedicine can offer counseling, therapy, medically assisted treatment for medications to help people get off these life-threatening and disabling drugs.

Representative Mustio talked about the stigma. That is a very real piece of behavioral health. I can't imagine what it would feel like to have a substance abuse disorder and walk into an exam room or a waiting room of a physician's office only to see maybe a coworker, a colleague, a family friend, and then how do you deal with that and potentially how would that impact further treatment?

You know, recently I broke my foot, for those of you that visited, and I have this large boot on, and we talk about future technology. I would love to have an X-ray machine on my phone, but that doesn't exist. Obviously, telemedicine is not going to solve all problems, but it can certainly solve a lot of them, and it certainly can help get me to the right location, if that's what I need, to get that X-ray that I should have.

I was really touched by the Representative's comments about the skilled nursing facility, and it made me think about, what could we have done better with technology? Had that skilled nursing facility had a telemedicine option, they could've contacted the physician directly. Oh, by the way, they don't speak English, so I could have pulled in an interpreter all on the same iPad. Oh, and the son or daughter that lives in California, I could bring them into the same conversation on the same iPad to have something that could otherwise not have happened without using telemedicine.

Home visits -- as I mentioned, I was a family doctor originally -- were really a great way to get in touch with your patients. I view telemedicine as the new home visit, the ability to have the provider once again get back into the patient's home as well as make that connection in ways that is difficult without using

telemedicine and the technology of today. Whether the provider comes to the patient by walking through the doors or zooming in virtually, that's a patient visit, and we feel it needs to be reimbursed.

Lehigh Valley Health Network strongly supports SB 780 and appreciates the work the Committee is doing in giving it a fair hearing. Thank you for the privilege to speak with you today, and I, too, will welcome any questions that you may have.

Thank you.

MAJORITY CHAIRMAN MUSTIO: You cut out, you cut out Representative Day and Representative Brown in your testimony. Do you want to re-read that last paragraph?

DR. BEAN: I want to also thank Representative Day and Representative Brown.

MAJORITY CHAIRMAN MUSTIO: No; I was referring to, in the paragraph you talk about the visit with Dr. Purcell.

DR. BEAN: Oh, yes.

Well, Representative Day and Representative Brown were here, and we actually had our teleneurologist show and examine what it looks like to see a patient virtually. The ability to actually zoom in from across the room, to have the patient's face taking up an entire screen, you can pick up subtleties like a facial droop of a stroke.

The technology is amazing, and really, we're ready to embrace the technology, as we have done, and continue to move forward.

MAJORITY CHAIRMAN MUSTIO: All right. I want to thank you.

PANEL III:

INSURANCE

MAJORITY CHAIRMAN MUSTIO: At this time, I would like to have the insurance panel come forward: Doug Furness, Sam Marshall, and Kim Kockler.

After the roll was taken and early on in the meeting, Representative Day, Representative Sonney, Representative Comitta, and Representative Briggs had joined us.

Okay. We'll continue with the same order as on the panel. Doug Furness from Capital BlueCross.

MR. FURNESS: Good morning.

Chairman Mustio, Chairman Readshaw, and the rest of the Committee, thank you for the opportunity to offer testimony today.

My name is Doug Furness. I represent Capital BlueCross here in Harrisburg. We insure approximately 800,000 residents in south-central Pennsylvania and the

Lehigh Valley.

CBC supports telemedicine. The good news that you're hearing today is everybody supports telemedicine. Insurers believe that it offers great opportunities to deliver quality care in the right circumstances and control costs. So it's good to hear that everybody is pretty much on the same page there.

While we do support telemedicine, we do have concerns with the bill as it is currently written.

First of all, we don't believe the legislation is needed, as we already do cover telemedicine. We cover telemedicine; we pay for telemedicine. It's growing. We are offering new services all the time.

We have an app-based, consumer-driven, primary-care product that all our customers are eligible for. We have telestroke coverage, and we have a behavioral health product that we are just bringing into the marketplace.

The good news is that the market works. You're going to have differences between payers. This is a market-driven system, and that should be celebrated. We believe we are at the forefront of that and are excited about our opportunities and what the future holds for us. As new services are proven to be effective and medically appropriate, we are offering them to our members and

covering them as well.

We also believe that the bill is unnecessarily broad by allowing any physician in our network to provide telemedicine services. Not every provider should or is capable of offering these types of services.

You heard from Dr. Desai from Children's Hospital. He made the comment that of course we're not going to set a broken leg via telemedicine. The bill would allow for that, because it says any physician in our network can provide telemedicine services.

It also says, the bill also says that insurers cannot deny coverage for service solely because it is offered through telemedicine. In the same example that we just talked about, insurers pay for coverage for setting a broken leg in a hospital. They pay for setting a broken leg in an urgent-care center or in a doctor's office. If that service were provided via telemedicine, the only reason we would deny it is because it was offered through telemedicine. The bill as it's written currently would suggest that we would have to pay for that. I don't think you want us to do that because of the impact that may have, will have, on cost.

And finally, I'm going to keep my -- I know my colleagues have similar comments. But I hear the comment about this is for rural communities, and it's important for

all of you to understand that telemedicine occurs in multiple different venues.

We have heard from a lot of hospitals, and the hospital telemedicine products are growing and innovating all the time, and they are innovating on their own. Insurers are not an impediment to that innovation. I think you have heard that here today. But it's important for you to understand that telemedicine occurs not only in hospitals, but it occurs in your living room or in your family room or in your child's bedroom when they are sick.

Capital offers a Capital Virtual Care app-based system. Representative Mustio referred to that as the "sick app." But we view that, and that was where we saw the greatest opportunity as a company, and we dove headlong into that by developing this app along with our partner in this, Amwell, American Well. And what it allows a customer to do is whenever they are sick or your child is sick, and we all know that our kids get sick in the middle of the night and not during business hours, and that's why you use the emergency room as primary care. This allows you to see a doctor at home and get a diagnosis and a treatment designation right away. And it is less expensive than an ER visit. So this is good. It happens.

And so the important thing to understand, though, is the limitations of this are the technological

limitations that I think all of you were struggling with in other areas, and that is broadband access in rural communities.

If I have my phone, if I don't have 4G wireless coverage, I'm going to have an inconsistent experience on our app-based system. And so if we believe this is going to help rural communities, I think we need to address that issue first, because a lot of us and a lot of telemedicine service is going to be provided directly to the consumer via app and tablet-based service, and I don't think we're -- the reason I'm bringing that up is I don't think any of us are talking about that or considering that, and that's something I think you should consider.

I'll cut my testimony off. I want to thank you for the opportunity to share my thoughts, and if you have any questions, I'd be happy to answer those.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Mr. Marshall.

MR. MARSHALL: Sam Marshall with the Insurance Federation.

"Insurer coverage (of telemedicine) over the past few years has grown substantially and we commend them on their efforts."

That's not our assessment; that's the assessment of CHOP that it gave to this Committee, and I think it's

important that everybody recognize that as we go through the specifics of this bill.

We cover telemedicine now. We recognize its value. You know, it was an impressive outline of all the things that it is and can and will do that we have heard from the previous panels. We understand that and we raise it and we promote it.

And it will go beyond primary care. It will go into specialties. It will go into trauma. It will go into behavioral services. We realize that. We're working with providers. And sometimes that gets overlooked in forums like this, but we're working with our network providers on that.

We do, though, when we cover any form of delivery, we do have a limit in the world of insurance, and sometimes it's an uncomfortable limit, but we cover proven value. That's what we look for when we decide and we work with our network providers to provide coverage: has it been proven to be effective.

You know, in the previous panel, you know, one of the gentlemen noted that there will be increased utilization. That's not what we object to. And he noted the real challenge in it is the question, will it be the right utilization? That's what we work for. That's what we do with our network providers. That's why we have prior

authorization. That's why we have standards. That's why we have protocol that we work out with our network providers, to ensure that it is the right utilization, that it gets better care, you know, and it genuinely saves money.

This is, as also has been mentioned, you know, one of the gentlemen noted that everything is going to increase exponentially as things move on. That's the way of technology. One of our concerns here with this bill is that you lock in standards of care and rules of practice right now that telemedicine will always be the same as in person. It won't be. It shouldn't be. I mean, it belies, anybody who has dealt with technology over the years, it belies the reality of technological advances.

I don't know what telemedicine is going to look like 5 years from now. I don't think anybody knows what it's going to look like 5 years from now. I don't think we want to lock it in and assume it's always going to be the same as in person. It isn't -- I hope.

As to the bill itself, our concern with the bill is primarily with Section 6(a), and that's what we read as the insurance mandate. We think it goes too far. As we read it, we think it says that every network provider or every service is entitled to coverage for a telemedicine service simply because it would be covered as if it had

been delivered in person by that particular provider.

The reality and our experience, as people who have to manage programs and come up with affordable care, is that some services and some providers may not be ready for telemedicine coverage. They may not have established the proven value that's a cornerstone of insurance coverage.

A lot of the providers we heard from in the previous panel, you know, they're superb. Nobody questions, you know, the capabilities of UPMC or Penn Medicine or CHOP or Lehigh Valley, you know. I mean, those are great outfits. They're not every provider that's in our network. You know, we're not integrated delivery systems where our network is primarily one particular provider, whether it be UPMC or Allegheny Health Network.

We as insurers on a national basis, we cover a wide spectrum of providers. To assume that each of them is going to have telemedicine programs that meet the standards you hear from from CHOP or UPMC or Penn or Lehigh Valley, that's just not the reality of it.

What we look at is, you know, and it's a question with the mandate in the bill, you know, can an insurer recognizing that say, you know what, some network providers or some services might not be qualified, might not be medically appropriate to be done via telemedicine. You

know, we want to incent, we want to reward Penn, for instance, for its program, but every other provider might not meet those standards. Can we therefore say, even though you're in the network, only some of you we find meet the quality standards that we would set up?

Can we require prior authorization of the service provided via telemedicine if we don't do it -- if it's performed in person? It's a question. I don't know what the answer is under that bill. So I say maybe, maybe not.

We use in the world of insurance, you know, we manage benefits. That's what we do. What we're not sure of under this bill is whether we can manage benefits when they use the innovations of telemedicine any differently than we might if we do it in person. We think it only makes sense. We don't think it is the same. We heard testimony, you know, eloquent examples of where it isn't the same.

We also think that in Section 6(a)(3), there is some added confusion. I realize that Sections 6(a)(1) and (a)(2) address coverage parity. In Section 6(a)(3), it sort of expressly says here that you don't have to have payment parity.

We agree with that concept, but it's a question. What if an insurer and a provider can't agree on a telemedicine rate? Can that provider still perform

in-person care for the insurer? Would it still be a part of that network for that? I don't know.

Can the insurer set different rates among its network providers? Can an insurer say, you know what, Penn, yours is a gold standard program, but another provider, you know, you don't meet that same thing, so we're going to have a different reimbursement rate. I'm not sure. I'm not sure what it all means.

Also, we were given, you know, last week we were given some amendments that may go into the bill. One of them -- and it does deal with a licensing question. Our focus is on insurance, but it was a licensing concern that said that the licensing boards would be prohibited -- as we read it -- the licensing boards would be prohibited from having standards of care and rules of practice different for telemedicine than for in-person.

That's a change from the bill as it came over here, but I'm not sure why you would want to borrow the licensure boards for recognizing that standards of care and rules of practice for telemedicine might be different than for in-person. They very well might be. It depends on how it all evolves. What is the training that goes into it? You know, what are the technological qualifications for it? You know, how many pixel resolutions do you have to have? I mean, those are logical things to deal with.

I would say what gets lost in all of this, and it's unfortunate, is that generally we and the providers do work together. If we didn't, I mean, if we didn't do any work together, that's all this General Assembly would deal with. I mean, we usually work together, and that's particularly true with network providers.

You know, some of the things that we've heard today, we welcome the chance, I mean, on behalf of those of us who negotiate contracts with our network providers, we welcome the opportunity to work with them on those programs. Not all network providers are equal. You know, we have different negotiations with one versus another within any network. But we think it's important that that be done on a collaborative basis, and our real concern with Section 6 in this bill is that it takes away that ability to collaborate.

Thank you.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Kim Kockler from Independence.

MS. KOCKLER: Thank you, Chairman.

We appreciate the efforts today of Committee Chairmen Mustio and Readshaw. And I also thank the Chairman, Chairman Mustio, for visiting us, along with Representative Quinn, at Independence Blue Cross in Philadelphia to discuss how we cover and look at

telemedicine, not just today but going forward.

Independence Blue Cross has been operating in the five-county Philadelphia area for 80 years. We have 10 million people across the country that we cover and 2.5 million in the five-county Philadelphia area. So we think the backbone of what we do at Independence is really work in cooperation and partnership with providers. So it puts us in a bit of an odd spot today, but one we're not -- it's not foreign to us.

Our job is harder, it always is, because you get to hear all the great and wonderful things that happen via telemedicine. No one is disagreeing. Who would disagree with helping to detect child abuse, to help stroke victims, to help seniors who can't get around, through a televisit. None of us are disagreeing with that.

So, you know, I hope that whatever you take from today that you understand that these are services that we do embrace, that our folks are looking at all the time in cooperation with our provider partners. And I know several strong IBC partners are in the room today giving you testimony. So I hope that's not lost on this Committee.

But what I think we need to drill down to, and I know we will in subsequent conversation and as this Committee proceeds. What we need to drill down to is, what's the reality of this bill as it is written and as it

has come to us from the Senate. And unfortunately, as much as we do value telemedicine and we do value our provider partners, this bill is not something we can support at this time.

We agree, and I will at the risk of being repetitive from my colleagues, we do accept that you want to mandate coverage for telemedicine. We accept that. We accept the mandate. What we don't accept is exactly the phrase we're talking about. We don't accept having to cover for every named provider in this bill, and I would urge you, if you haven't looked at that definition, look at the definition of "provider." Every person named in that bill would have to be reimbursed by our company if they are in our network.

And I'm not just talking physicians; we are talking about dentists, optometrists, physical therapists, and others. That's a wide, that's a wide swath. That's lots of folks that we don't know if they can do telemedicine or they can't. But when you look strictly at this language, if they do something in person, we have to pay them to do it via telemedicine.

So I just urge us to now get to maybe, you know, the nuts and bolts of what the legislation does and doesn't say, because it will have real ramifications in the world of insurance. And I know that's not a fun or popular thing

to have to say, but those are the ramifications.

You will not want us to cover everything every provider brings to us. You won't want us to do it for quality reasons and you won't want us to do it for cost reasons, because you won't like the premium on the other side of that.

So we would just caution that, look, we feel this is progressing very well. We feel that telemedicine is just as you have heard today. It holds great, great promise. But what we don't want to do is write the blank check and open the floodgates to things that may or may not be good quality and will definitely raise the cost of health insurance.

So, Chairman, we thank you. We know there will be more discussion on this, but we definitely appreciate you convening us today and giving us this opportunity.

MAJORITY CHAIRMAN MUSTIO: Thank you very much.

PANEL IV:

INTEGRATED SYSTEMS

MAJORITY CHAIRMAN MUSTIO: At this time, we would like to have the representatives from Highmark and from Allegheny Health Network.

Good morning.

MR. YANTIS: Good morning.

Similar to how Dr. Hollander kicked off his testimony, I think I'll echo his words. I feel like we're in a little bit of a unique position here coming at this from an integrated delivery and financing system. So I'll start it with that.

For those of you that don't know me, I am Mike Yantis. I am Vice President for State Government Affairs for Highmark. Joining me is Betsy Taylor, Senior Counsel and government affairs lead for the Allegheny Health Network.

Highmark is part of an integrated delivery and financing system. We provide commercial and government products in Pennsylvania, West Virginia, and Delaware. We work closely with Allegheny Health Network, which is our provider arm.

We are more than just an integrated delivery and financing system, however. We have extended provider partnerships throughout the Commonwealth, unique and different partnerships with Penn State Hershey, with Lehigh Valley Health Network, with Geisinger, and we are continuing to forge partnerships throughout the Commonwealth in unique ways that recognize and benefit the communities that those providers serve.

Our thoughts and our opinions on this legislation

are driven by the information that we have as an insurer and a health system. We're not going to read our testimony to you. You can do that. We're going to get right to the point. And at the risk of oversimplifying this, and invoking the words of my mother, who used to say, Michael, you're such a simple sh--, bleep, I'm going to make it simple.

Telemedicine, virtual health, is important to the Commonwealth. Highmark and AHN promote it. We support it. We value it. It should be reimbursed.

Similar to our insurance colleagues, we accept the mandate. It should be there. We already do it at Highmark. The issue and I think what needs to be addressed is, this Committee, this Legislature, should not place an artificial framework around it and connect it to the in-person setting.

I think we heard various times throughout different testimony today that virtual health is transforming the way health care is being delivered. We should not tie it, we should not anchor it to that type of a setting -- how you evaluate it, how you look at it, how you cover it, or how you reimburse it. It is more important, it is more significant, it is advancing too quickly to put that constraint around it.

You heard folks talk about Medicare and how they

are beginning to advance and relax their standards. They are relaxing their standards, but they still have legislative barriers that they have to overcome, that they have to go back and change to increase their coverage for telemedicine.

You heard reference to 38, 36, 30-some other States have telemedicine legislation. Just this past year, over 100 pieces of legislation were reintroduced in many of those States because they had to go back and make changes, because 5, 10, 15 years ago when they created their telemedicine statute -- virtual health -- they weren't forward-looking enough and they had to go back and make changes, because medicine and technology advance far too quickly.

So we need to create a thoughtful framework that encourages insurers and providers, similar to the model that Highmark and AHN have, to figure this out, to promote telemedicine, and to focus on the patient or the customer.

Betsy, anything to add?

MS. TAYLOR: No. I think Mike has really summarized our perspective. I think probably the more meaningful and valuable thing for all of you is to just get to the questions and answers so we can tell you about our experience and answer any questions that you have or from the other panelists.

MAJORITY CHAIRMAN MUSTIO: Thank you.

You can go, and we'll figure out where we're going to seat you.

All right. At this point we have, it looks like a limited number of seats. We do have some on the side. So if we could have the provider panel and the insurance panel come back up.

I suspect there's going to be a decent amount of questions for the insurance panel, so if we could get them, those members, close to microphones, that would be great.

And then from the provider panel's standpoint, if you could sit over at the side table -- we'll call that the kids' table -- and then maybe grab some of those front-row seats.

I know what's going to happen here, because the insurers have said that they work so well with the providers and they get along so well, that this is going to be a very good conversation.

Right now as far as asking questions, I have Chairman Readshaw and Representative Christiana. If other Members want to ask some questions, please let me know.

Chairman Readshaw.

MINORITY CHAIRMAN READSHAW: Thank you, Chairman.

My question will be directed to anyone from the insurance panel, and it's not a health-care question, nor

is it really an insurance question. I hate to say it's a political question, so we'll call it a procedural question.

Now, this has been bothering me all summer, and this is the first opportunity that I have had to perhaps get a response, and I'm referring to the action in the Senate. It was referred to committee on June 22, 2017. It was reported as amended on January 30, 2018. First considered; laid on the table; removed from the table. Then it was amended on second consideration on April 24th of this year. Laid on the table; removed from the table.

Now, on second consideration, with amendments, on June 1, 2018, it was unanimously voted 49 to 0. It was then referred to Appropriations, reported as committed. Then the third consideration and final passage was June 13, 2018, again a unanimous vote of 49 to 0.

Obviously I'm bewildered, so I have to ask this question: How did it go through all this process and all this procedure without your concerns for this legislation being considered in the Senate?

MR. MARSHALL: Now, I think I speak for all the Blues: We're bewildered, too. We were disappointed. And, you know, it happens in this business. You know, that's why we're still here.

MINORITY CHAIRMAN READSHAW: Well, I understand, and as I said previously, I have been here for 24 years, I

have been on this Committee 24 years, so I'm very familiar with the process and I'm very familiar that sometimes you just simply get shot down. But were these questions that you have raised, were they in any conversations with the Committee at the time or on the Floor of the Senate?

Okay. So you had all these conversations in the Senate, and they saw fit just to unanimously vote it out of the Senate and send it over here. Is that---

MS. KOCKLER: Representative, the bill was gutted and amended -- well, not gutted, but it was amended, as you see by all the stricken pages.

MINORITY CHAIRMAN READSHAW: Right.

MS. KOCKLER: It was almost rewritten in some senses.

I won't say that we weren't heard at all in the Senate, but we have all been consistent in how we don't want to open the floodgates on this thing. That, unfortunately, has not been addressed in this bill at all as it moved through the Senate. It has never been addressed.

MINORITY CHAIRMAN READSHAW: Okay. So just for the record then, I'm concluding that the Senate didn't hear your pleas, nor was there any consideration of your concerns. Is that accurate?

MS. KOCKLER: I won't say there was not any, but

I will say it was a bit of a different discussion in the Senate in that the focus was much more -- and I defer; my colleagues can speak on this as well. It was characterized as a very -- this was a rural-area issue. This was about access in rural areas, which, in part, it is. But, you know, we kept stressing that we don't all operate in rural areas, and the impacts will be significant.

So I will just say, it was a little bit of a different conversation. And we never had this opportunity in the Senate. We never had the opportunity to be before a full committee, providers included. I mean, we never had the opportunity for a public hearing like this. So this, to us, is progress. We're having the discussion.

MINORITY CHAIRMAN READSHAW: All right. Well, I just had to clarify that.

As I can tell you, since it was unanimous, there are three Senators in my legislative district, and obviously since it was a unanimous vote coming out of the Senate, they all supported it. So there's a lot of considerations here.

But I thank you for your response. I'm sorry that you were unable to be heard in the Senate, and I'm sure if they read the report from this meeting, they can or cannot defend themselves.

Thank you very much, Mr. Chairman.

MAJORITY CHAIRMAN MUSTIO: Yeah. Just so Members know, this hearing is being streamed live on PCN, and it will be rebroadcast on television tonight at 7. So perhaps the Senate or your Senators can watch it tonight and answer that question, too.

Representative Christiana.

REPRESENTATIVE CHRISTIANA: Thank you, Mr. Chairman.

I would like to begin my comments and questions with acknowledging the gentleman and the Senator from Beaver County, Senator Elder Vogel, for his leadership and acknowledge his ability to work with interest groups that have had inverse interests and a very forward-looking bill, an innovative bill. I have got to give him a particular acknowledgment for being able to get this bill across the finish line in the Senate, as the Minority Chairman mentioned, in a 49-to-0 fashion.

I would also like to acknowledge the leadership of the gentlelady from Bucks for her bold leadership and commitment to making our health-care system centered on patients and physicians and having reasonable, responsible legislation crafted.

So I would like to begin with the repetitive characterization of the insurance mandate or the coverage mandate. And I think it's important, because there are a

lot of health-care services, treatment plans, prescriptions, that are not covered by health insurance.

Occasionally the Legislature will intervene in that free-market relationship and marketplace and we will pass legislation that requires coverage, an insurance mandate as we would like to call it up here, a coverage mandate, requiring that those health-care services, procedures, drugs, be covered.

In spite of the characterization, or maybe not in spite of it, but just to make sure that it is well documented, because that's not what we're talking about today. We are not requiring that additional services be covered or new services be covered.

All of the services and procedures that are covered in an insurance policy are going to be covered under this bill -- no more, no less. I think you were very clear in explaining that. But I think it's the context in the Legislature where an insurance mandate is perceived to be something, and I believe this bill is not. Not that it isn't a mandate and not that it doesn't deal with insurance, but in the traditional legislative context, I think that's worth noting.

And so to say that every service that is covered in-office in a health-care policy will now be covered if it was done via telemedicine does seem like, as you mentioned,

a wide swath or a blank check. But to be fair, that's not the only control of whether or not you would pay for a broken leg that was done via telemedicine. There are other controls that would ultimately determine whether or not you would cover it.

What this bill says, though, is that it just cannot be denied purely for the fact that it was done via telemedicine. So that broken-leg hypothetical, there are other controls in place, like how much the provider will be paid for fixing a broken leg via telemedicine. That physician must be in network. So we're not talking about physicians that aren't in your network that would be fixing that broken leg. It must be a covered service, which in this hypothetical, a broken leg, which would probably be covered. But not all services are covered, and this doesn't say that more services will be covered. So there is a limitation on what service can be provided. Those controls are already in place.

And there's also two other limitations on whether or not a telemedicine appointment or service would be covered, and that is that it must be consistent with the insurer's medical policy and it must be medically appropriate.

Now, my first question for you, Mr. Marshall, is in your written testimony, you seem to have some confusion

about those two limitations, that in order for a service to be covered, it must be "consistent with the insurer's medical policies" and it must be "medically appropriate."

Your two-part confusion, though, could you elaborate on why you are confused about those two phrases, because they do seem rather ambiguous maybe to the common person, but in the physician-insurer context, those are not subjective phrases. They actually have very objective definitions, correct?

MR. MARSHALL: I wouldn't, I wouldn't necessarily agree with that. I don't think that that's actually some of the reason I'm confused.

REPRESENTATIVE CHRISTIANA: Well---

MR. MARSHALL: You know, for instance, "medically appropriate," that's determined by who?

REPRESENTATIVE CHRISTIANA: Well---

MR. MARSHALL: I mean, and going into medical policies, if an insurer's medical policy is that it is not yet convinced that a particular specialty is appropriate to telemedicine, that it hasn't proven to be effective in an overall sense, can the insurer then say, you know, our medical policies don't extend coverage to telemedicine for this particular service?

REPRESENTATIVE CHRISTIANA: Well, my only---

MR. MARSHALL: That's a question.

REPRESENTATIVE CHRISTIANA: So "medically necessary" or "medically appropriate," as the language says, sounds very general to me as a former car salesman and, you know, a layman. But if I look at an insurance policy, "medically necessary" or "medical necessity" has a very lengthy definition in some insurance policies.

In fact, I'm looking at one: It must be clinically appropriate. So that broken leg, via telemedicine, I don't think would be clinically appropriate and, therefore, would not be paid, correct? Because that would fall outside the bounds of "medically appropriate," correct?

MR. MARSHALL: Well, for one, I think -- and this is one of the questions. This is why it's good to have this discussion.

I'm not sure that everybody would say that "medically appropriate" is one and the same as "medical necessity." You are reading the definition of "medical necessity." I think that can be different than "medically appropriate," because what we're -- and that's why it's good to have this discussion.

What we're trying to figure out is what level of control, what level of involvement. I'm not even talking about control, because these are network providers whom we negotiate contracts with.

REPRESENTATIVE CHRISTIANA: Okay. But I don't -- I have a few other questions, and I know the Chairman, he likes to keep me short and sweet, which I don't think I'm going to meet today.

But "medically necessary" versus "medically appropriate" seems like a grammatical error, a change of a word, which words matter. And if that's your recommendation, is, well, it should not be "medically appropriate," "medically necessary" does have contractual policy implications which are lengthy, and I'm not going to read them all. I'm happy to read it. But it is very well defined what "medically necessary," which includes "clinically appropriate," means.

So not to mention, "consistent with the insurer's medical policies" is defined in your recommendation -- you made a recommendation of an alternative to this bill, the Rhode Island language, and you sent us some draft language.

And just so it's clear, your recommended language says so long as such health-care services are "medically appropriate" to be provided through telemedicine services subject to the terms and conditions of the agreement between the insurer and the network provider. I don't see much difference between that recommended language and your suggestion and the language in the bill, but if that needs cleaned up, I think I would be willing to offer that.

I would like to talk about another concern that you had in the prior authorization, the potential requirement or the hypothetical that the bill does not address a prior authorization requirement. I think your testimony said that a prior authorization could be interpreted as being appropriate in this language.

Are you suggesting that your members or anyone from the insurance industry, are you recommending that there be a prior authorization requirement? Are you in support of a prior authorization requirement? And do you read the bill as allowing a prior authorization requirement?

MR. MARSHALL: I'm not recommending a blanket prior authorization requirement any more than we would recommend blanket coverage, which is one of the problems here. But there may be, and different insurers are going to vary on it, and, you know, you may have different requirements within your own network, because you have a wide variety of providers in that network.

But you may, as telemedicine evolves, say, you know what, we're still getting comfortable with this. You know, we realize it increases utilization. We want prior authorization to make sure that it's the right utilization. Can you require prior authorization of a telemedicine service if you don't also do it for in-person?

That's a question.

REPRESENTATIVE CHRISTIANA: Correct.

Well, so my question then, practically speaking now, due to the inconsistencies, the lack of uniformity as it relates to telemedicine appointments, how would you recommend to my constituents or the public that they find out whether or not they are currently covered?

Because I have heard horror stories of people that get stuck in traffic from Bedford to Pittsburgh, because they weren't covered, and had to hop over the guardrail on their way to take care of themselves. Those are realistic problems. So realistically, how should someone find out whether or not they have coverage?

MR. MARSHALL: Each insurer, you know, I think now does -- and, you know, we don't have, for better or worse, we don't have that many insurers in Pennsylvania, and we certainly don't have that many in any particular region, maybe three or four at most. But each insurer does publish now, and if it's unclear, then I guess we all ought to take steps to make sure that it's clear.

REPRESENTATIVE CHRISTIANA: It is unclear. So how would somebody get clarity, a patient get clarity of whether or not -- while the marketplace figures out how to work this, what is your recommendation for those people to find out if they have coverage?

MR. MARSHALL: Our recommendation is that insurers, that each insurer clarify with each policyholder---

REPRESENTATIVE CHRISTIANA: To me, that's a de facto -- I understand. That's what I would recommend to my constituents, which in many ways is a de facto prior authorization. You have got to go find out whether or not you have to drive from Bedford to Pittsburgh to see the physician that is treating people in Bedford for the same services, but you may or may not be covered.

MR. MARSHALL: No; I'm sorry. Maybe we're talking---

REPRESENTATIVE CHRISTIANA: They need to find out whether or not they have coverage, and I'm just saying---

MR. MARSHALL: You know what, Representative? You're exactly right. And you know what? If somebody says, here, every insurance company shall notify on an annual basis, or whatever it is, a policy renewal and should put forth -- you know, you can have it reviewed by the Insurance Department -- put forth clarification on just what telemedicine services it covers and for which providers, okay. That's not prior authorization in the sense that---

REPRESENTATIVE CHRISTIANA: I know what -- I'm saying, I'm saying it is implicitly serving as a prior

authorization, because people do not know. And I'll go back to another practical problem.

MR. MARSHALL: Yeah.

REPRESENTATIVE CHRISTIANA: Your testimony says that telemedicine's "impediment so far isn't so much insurance as patients being comfortable with it." Your general, I'd say rather convenient assessment is counter to what I have heard from patients and physicians.

In fact, one highly skilled specialist that I met with on this issue, who treats patients that are -- doesn't treat patients that are uncomfortable with telemedicine; he's treating patients that not only are comfortable with it but want it. But the number-one impediment that he told me between him and his patients having access to him is insurance.

And so I can appreciate that your characterization is that it's about utilization, but we're not forcing anybody to utilize it. We're just allowing the people who want to utilize it to be able to.

MR. MARSHALL: If I could just, you know, what I meant in the patients not taking it up? You're right, the patients who take it up are fine, but what a number of our members have found, where they offer telemedicine coverage -- for instance, for primary care -- is it's such a small number of patients utilize it, get their care through that,

that it's actually, it's not cost-effective for the carrier to continue.

Because we have to set up infrastructure, too. It doesn't come at no cost to us. It's actually, for that particular carrier it has been shown, and others---

REPRESENTATIVE CHRISTIANA: But that is a distraction---

MR. MARSHALL: Excuse me.

REPRESENTATIVE CHRISTIANA: But that is a distraction, and with limited time, that is a distraction from what we're trying to do.

If we were trying to force people to use telemedicine, but that's not the language of the bill, and I just think it's a distraction from what we're trying to do.

MAJORITY CHAIRMAN MUSTIO: Representative Christiana---

MR. MARSHALL: I apologize. My---

MAJORITY CHAIRMAN MUSTIO: Representative Christiana, it's now a nonvoting session day, so we can go beyond 1.

REPRESENTATIVE CHRISTIANA: Yeah.

MAJORITY CHAIRMAN MUSTIO: And I'm going to get you into the second round, because we have a list of questioners, and I'm not sure everybody can stay here the

entire time.

So here's who we have. We have Representatives Mentzer, Day, Kortz, Brown, and Helm. Do any of those Members need to leave within the next 4 hours?

(Laughing.)

MAJORITY CHAIRMAN MUSTIO: All right. We're going to go to Representative Day.

REPRESENTATIVE DAY: Thank you, Mr. Chairman.

I think I'll be brief, but there's a couple of points that I wanted to make.

First, thank you for doing this, Chairman. You have done an outstanding job with this.

Providers and insurers -- I want to make this statement -- both play a vital role. I think Ms. Kockler said this as well. Both play a vital role in the effectiveness and cost of health-care insurance. And I just want to get that out on the record for everyone watching here today. It's a vital balancing act that we do.

And Chairman, I'm on the Insurance Committee, and usually I want an issue like this to be referred to the Insurance Committee -- I have talked to you about this -- and handled by Members that deal with, you know, this provider and insurance balancing act that we try to do and that should be done.

With that being said, in my 10 years, I don't think I have ever seen an issue handled more thoroughly than the way you have done this issue, and I want to thank you for that. Reaching out to Members, despite this being your last term in office, really working hard, running hard to the finish line, and I want to thank you for doing that.

We probably have more information. I think we heard testimony. Definitely this is a great opportunity, is what one insurer said, that they didn't have in the previous part of the passing of this legislation. So bravo, Mr. Chairman.

And the providers are crucial to petition for new ways to deliver services. And I was at Lehigh Valley with the good doctor there, and he did an outstanding job, along with his entire team at Lehigh Valley, talking to us about that last week.

Insurers are crucial to evaluate and guide the effective procedures. They keep saying it over and over, and I want to outline that. In my 10 years, I have always looked at -- 6 ½ of those years I was on the Appropriations Committee. We have to look at costs.

A lot of the costs that we're here talking about will become government costs as well. It's crucial that the insurers play, and they have always played, a role to help us manage those costs to deliver what I consider

effective procedures that will bring the best procedures, you know, to bear for patients.

In the case of telemedicine, it's obvious to me that it saves costs. Our policy, I believe, should be that the savings is shared.

The providers probably would like to, if I was a provider I would like to have all the savings, you know, remain with the hospital, because they manage many costs. And right now they have implied to me during our hearing or our meeting that they have been covering the unreimbursed telemedicine. So they do that in many areas, and I'm sure they want any savings to use for that and providing other services.

However, also I believe that these savings should be shared with the ends of the insurers, not necessarily their profit margin but the ends of the insurers to keep costs down, and as other costs are rising, to use these savings to keep costs down that we all face as Legislators when our constituents say, health insurance premiums are way too high.

I always think that both are very important in the process, providers to keep patients safe and insurance to have that effective thing, or that effective effect.

Now, my question is probably for both, but I'll start with someone from the insurance side.

If you were given 90 days, do you think you could negotiate with providers an agreement, like you do with your agreements with providers, that does two things: one, what services should be covered by telemedicine, because we heard that this bill has a very wide swath and it's hard to predict what the cost result is going to be. So one, do you think if you had 90 days you could negotiate what services, and also what rates? Because I mentioned that I believe that it might not have to be 100 percent billable or reimbursable, that that savings sharing could be in a negotiation, hey, for this type of procedure, we save a lot of money. Because we don't transport a patient from this hospital to another hospital by helicopter, we save $10,000 on one patient, so we're willing to take half, you know, half of the reimbursement.

Do you think if you had 90 days, you could negotiate what services and what rates and have an agreement like the normal procedure of negotiation is?

MR. YANTIS: If it's all right, I'll jump in. I know I'm not on the insurance panel. I kind of feel a little bit like Charlie-in-the-Box from the Island of Misfit Toys. But we'll address that from both the insurer and the provider perspective.

The short answer from the insurance side is, yes, that's what Highmark does currently. We have a very robust

telemedicine coverage and reimbursement policy process. Much of that is because AHN has gotten us smarter on the issue, and our other provider partners have gotten us smarter on the issue.

Now, is it 90 days? I don't know that that's the magic number. Provider negotiations are sometimes complex, and this would be an element of it. But I think the crux of your question is, can the insurers and providers sit down and negotiate this out from a coverage and reimbursement perspective, and the answer is yes. That's what we currently do.

Now, I know Betsy has a little bit of additional insight from the provider side that I think will help inform this.

MS. TAYLOR: From the Allegheny Health Network's perspective, we would love to have that same dialogue that we had with Highmark with other insurers, but we have been rejected. We don't even get past the contracting folks who say, you have to use an exclusive vendor platform; your platform isn't good enough.

So we welcome the opportunity to have that discussion, and valued it with Highmark Inc, and believe as health care evolves, in order to change the way we deliver care, we have to change this adversarial positioning that providers and insurers have, and we have demonstrated at

Highmark Health that we can do that. And not only does AHN benefit from the robust and broader reimbursement coverage that Highmark has provided, but any hospital and health system that contracts with Highmark now benefits from that.

So it is a dialogue that we want. You just can't legislate that dialogue.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Yes; Judd Hollander.

DR. HOLLANDER: Yes.

So this, to me, breaks down into two categories. There is the services we already have and we have already agreed on rates, albeit they are not telemedicine rates and those patients receive them, and there are services that we might want to add on that telemedicine affords new.

My read of this bill is, these are services that are already being reimbursed. I don't think any health system, hospital, or provider has ever asked for more money to do the services.

There's a couple things I know as a physician: Because I can now do it by video, I don't want to give up dinner and work an extra overnight shift. So I'm still going to work at whatever time and coming home at whatever time, so I'm not doing a ton of new patient care.

I think that although I would love to have payment parity, that's not what we're talking about, and I

naturally assume that that payment that is negotiated will be somewhat less than we get for in-person care, which means, frankly, for a provider to make the same amount of money, they'll have to work longer.

You know, you speaking of shared savings I think is a really important concept, but sometimes we end up not sharing risk. Growing an infrastructure may have a seven-figure price tag on it, and so just saving the amount of money on a patient-care fee is not the same as sharing the cost on the infrastructure so we can save the money on the patient-care fee.

So I think if we're going to talk about sharing the savings from reduced reimbursement rates, we also have to talk about sharing the amount of money we need to invest to be able to do the service at that reduced rate.

And my final comment on this topic is, I don't think we could sit around this table nor do I think we could negotiate specific things that we would want to cover and not want to cover. In our experience -- and Jefferson did it a little different. We threw mud at the walls and saw what sticks. We weren't getting compensated for anything. It turns out, and I don't mean this as a joke, but it sounds kind of funny. One of our most popular things was urology, post vasectomy care. It turns out guys don't mind flipping an iPad post-vasectomy care, and

presumably it saves a bumpy, bouncy trip in the car to come in, and that is a high use case we wouldn't predict.

We have done focus groups with women post breast surgery. You might not think they would want to show it on a video, but the focus groups uniformly show, the majority, not all, but the majority of patients find it more private to sit at home on a video than in a paper gown in a room where people are coming in and looking for rulers and stethoscopes and stealing the otoscope and they only get seen by their surgeon.

You also might not think when you're delivering bad news and telling someone they have cancer, they'd rather have it by video. It turns out not having to drive home 75 miles after you are told bad news is a lot nicer than being told you might only have 3 months to live; good luck; drive home. It also lets them have all their family in the room when they receive the news.

So my concern is, the bill as it is written is broad. The payers see that as a bad thing. I see that as a good thing, because at the end of the day, if something doesn't work, the providers are delivering care to improve the health of their patients. They shouldn't be doing things that don't work. They shouldn't be setting bones, although I think that's a ridiculous analogy, because I do see orthopedic stuff, and patients don't call and say, I

have a broken foot or a broken leg; they call and say, my leg hurts and I don't know what it is.

And I have had a patient who tore their medial collateral ligament who would have gone to the ER, but it was after 5 o'clock at night, and I actually was able to splint them at home and examine them, knew it was not broken, was able to figure that out, and they saw their orthopedist the next day, saving 6 hours in the ER on a Monday night and a set of films that wouldn't have been able to be seen by their orthopedist.

So we're going to learn as we're doing this. And someone on the provider panel I thought had a great set of terms: We need to make sure this has the skeleton, foundation, and the guardrails to make this go forward. And to me, we can't dot every "i" and cross every "t" in a bill, and I believe this bill does have the skeleton, foundation, and guardrails, and if someone -- and broken bones are different things. A little chip fracture of a finger could be dealt with in telemedicine, if that's what your differential diagnosis is. Your leg over there can't.

And so I think we just have to, like all other medical care, realize this is medical care. And inappropriate medical care is inappropriate whether it's in telemedicine or the emergency department.

MAJORITY CHAIRMAN MUSTIO: Doctor, thank you. And I think that you're great because you get to go back to the medical world. Well, in politics, when you have 8 days left in session and everything starts over after that 8 days, sometimes you come up with hypotheticals and you try to dot every "i" and cross every "t" and come up with other letters.

So that's why we did what we did throughout the summer, and that's why we had the hearing here today, and that's why we have a joint panel, because we want to cut to the chase. And I think Representatives that have asked questions right now have done a great job.

Representative Day, do you have one more follow-up?

MR. FURNESS: Can I respond, just real quickly?

MAJORITY CHAIRMAN MUSTIO: Oh; I'm sorry. Sure.

MR. FURNESS: On a number of what has been said here.

I think from Capital's perspective, and I appreciate the doctor's comments about the innovation that is occurring naturally. Well, we have processes in place. If his hospital is in our network, they can approach us and say, we have got this new delivery system that we think improves outcomes, saves money; what do you think? And we can come and they'll demonstrate it for us, much like we

experienced over the summer, and we can evaluate it that way.

What our experience has been is a lot of these new technologies, at least for my company, providers have been doing them for years, not billing them, not because insurers weren't paying for them but they were viewing them as value-adds to the service provided to the patient, and they have never asked us for that.

We have worked with a number of the providers in this room on specific circumstances. So, for example, last year, late last year, UPMC Pinnacle here in Harrisburg had an ER monitoring product that they approached us about and said, why don't you come over and let us demonstrate it to you for possible reimbursement. That worked. My experts in my company say, hey--- That's how it works.

To Representative Day's perspective, and I know this is going to sound a little odd, I don't know that you want to use the legislative process to list covered services. You don't want to do that.

I'll speak for my company. One of the services we provide on our app-based system is nutrition specialists. Now, I would imagine we could sit here all day long and probably never come to that. I don't know that you want to limit the provider community from developing new services, nor do you want to limit insurance

companies to develop new services that we find useful to our customers.

You're going to hear me continually say that the marketplace is handling this. You're hearing -- you heard from the providers. They're moving forward with a lot of this. And it's coming into the marketplace and customers are getting coverage for it as we show it to be effective, and that's what Sam's point was in his testimony.

If we have an in-person delivery system, now it has to go through numerous amounts of study and review, peer reviewed and all of that sort of thing, before insurers will cover it. We don't cover experimental.

The same thing Representative Christiana goes through here. Some of the comments you were making, you're right, but the language also says we simply can't deny something if it's delivered through telemedicine. That's the crux to the matter for us.

REPRESENTATIVE CHRISTIANA: Surely, but surely---

MR. FURNESS: You're a hundred percent right about a lot of those things, but the questions, these are the questions we're asking. If you remove that language from the bill, I think we have some discussion---

MAJORITY CHAIRMAN MUSTIO: Representative Brown has to leave at 12:30, Doug.

MR. FURNESS: Oh; I apologize.

MAJORITY CHAIRMAN MUSTIO: But just to be clear, there's nothing in the legislation that restricts Capital from paying for telemedicine services that aren't on the list. I'm telling you right now, their Section 1, you can pay for whatever you want, okay?

MR. FURNESS: Oh; you're correct.

MAJORITY CHAIRMAN MUSTIO: Let's go to Representative Brown.

REPRESENTATIVE BROWN: Thank you, Mr. Chairman.

And thank you all for your testimony, both from the physicians and the insurance and the Superintendent. Everyone offered a lot of great information. And I think my question is pretty much surrounding a lot of the other questions that have been answered and spoken about with the concerns.

And you just left on the topic a little bit of how you cover and the protocols of when you decide to cover. So the list in our binder here is pretty interesting by company on who covers what, and there's still a lot of red of no coverage.

So when Sam mentions "medically necessary"/ "medically appropriate," and then, Dr. Hollander, you then spoke about the fact of pretty much, you know, letting the physician decide what's medically appropriate, what's medically acceptable, which I think is just a common issue

that we always have anyway, really allowing the medical care to happen what's best for the patient, and that's always a problem.

So my question is, when you talk about "medically necessary"/"medically appropriate," how is that determined on, like, what documentation do we need? Like, you know, normally when a pharmaceutical product goes through, it's a clinical trial and there's all, you know, this--- Now, you mentioned a couple of focus groups and then you further talked about, you know, well, we have to determine that it's helpful.

Like, what documentation are we looking for to say it's medically appropriate or medically necessary to give the coverage? So we'll give coverage, but it has to be medically appropriate or medically necessary. Well, what documentation tells us that?

MS. KOCKLER: So I'll take a crack at it.

In terms of "medically necessary" or "medically appropriate," and just so we're all clear on this, neither of those terms are in this bill today. Neither is. So while we can talk about it, it's not in here.

So when something is -- when a medical necessity determination is made, it is a disputed service between us and a provider. And this is sort of -- it can sometimes be on the front end in a prior authorization situation or it

sometimes is on the back end and then after the fact.

We have folks that look at it from just a pure coverage standpoint. If a patient doesn't like that something wasn't covered, we're going to make a medical necessity determination. It comes in. We look at it from, is it a covered service, first of all.

But if it's a medical necessity determination, someone of a medical, a doctor, has to make that determination for us. We look at criteria. We look at literature. We have input from local physicians. So we do make those determinations. It's not in a vacuum.

But what I actually think we're losing sight of is, payment between providers and insurers is exceedingly complicated, and I think we all have to admit that. It's a complicated business that we're all in. So your impression may be that we're not paying for telemedicine. That's not true.

Are we all paying for it the same? No, we're not. You look at it. We're paying for primary care. We're about to get into telebehavioral health at Independence. We don't do everything Highmark does. Full admission.

But we work differently with our providers. We have value-based agreements with some of our providers. I hate to go into this. This is, like, way in the weeds.

But we reimburse our providers, and we have systems in the room that we have these agreements with that say, whatever you're going to do in this DRG, in this case for this patient, we're going to pay you X. However you do it is on you. If you use telemedicine and save yourself some money, great. That's shared savings.

I'm just trying to convey that this is -- these are very, very complex. We don't always look at everything as a one-off. There may be great programs in this room that we're not aware of yet. If they have great outcomes, we want to see them.

But this is the yin and the yang of how we work with our provider networks. And it's not straightforward and it's not simple, and I'm sorry we can't make it straightforward and simple.

REPRESENTATIVE BROWN: No, and I get that piece of it. And I think because of, you know, one of the physicians talked about the new technology with, you know, feeling the belly almost, you know, through the phone and things like that.

So I think that the piece of saying that -- not even what's in this bill but the technology piece. So if we're going to say coverage of, you know, what has been done in person versus telemedicine, but the technology piece of the protocol of how you continue to say that that

works, that that new procedure or new technology will work, you know, what is the protocol of the information that needs to be present and that needs to be able to say that it's, you know, covered?

And I think that that's where my question lays a little bit as we move forward, is the protocols of the newest technology and moving forward. And we discussed it a little bit about what needs to be documented or meeting with the provider and showing. But that's really where I think, when I look at the chart of what's covered, you know, right now and how we're going to look at that, that's where the protocol is, right?

And I hope I'm not confusing you completely, but I think you get what I'm saying as far as the technology and moving forward.

MAJORITY CHAIRMAN MUSTIO: Thank you.

MR. MARSHALL: Again, Representative, just on your point, we all want, as insurers, we want cost, quality, and access, too. I mean, you know, we're all about holding down costs. I mean, there's a lot of pressure on that. And we're all about giving our policyholders access to quality care, and that's one of the things that you go to here.

You know, each insurer is going to have, you know, we have medical directors. We have, you know, people

who spend their lifetime working with our network providers to outline and provide for just what we cover and how we pay for it. Sometimes we pay for it in the holistic sense; sometimes we pay for it on a piecemeal sense. That varies with each insurer and within a network. We don't treat everybody in the network the same.

One of the challenges you have here is that an insurer may say, you know what, Provider X meets the quality standards to do telemedicine, but we don't think Provider Y does. Provider Y says, okay, so you're covering telemedicine for him but not for me; that's not fair. Those are the things that actually you do negotiate as you are working within your network. You know, it happens on both sides.

I always get a little concerned when I hear somebody say, hey, some insurers won't even talk to me about telemedicine, because there aren't that many and they usually mean somebody I might represent. Well, here, give me the name, because I'll make sure that they do.

MAJORITY CHAIRMAN MUSTIO: I think the legislation is getting to the point where we shouldn't have to do that.

Representative Mentzer.

REPRESENTATIVE MENTZER: Thank you, Chairman Mustio.

Believe it or not -- and I hope you don't believe it -- I'm reaching the ripe age of 62, and throughout the last 20 years I have had high pressure in my eye, which is symptomatic of nerve damage to your eye which can result in glaucoma.

So my question is, would the insurers have to pay for that under telemedicine, and if so, how are they going to get that big piece of equipment into the home so that they can take the pressure, and how is the doctor going to look into my optic nerve to see whether it has changed? That's my first question.

So would you have to be reimbursed? In this legislation, would that be a reimbursable eye to treat?

MAJORITY CHAIRMAN MUSTIO: Dr. Hollander.

DR. HOLLANDER: So I'm not on the insurer side, but I will say, coming back to the comments on skeleton, foundation, and guardrails, there are eight devices in the world that could do what you asked, that could be seen by a remote ophthalmologist. None of them happen to be in the United States. All eight that I know of are in India.

So would you want telemedicine at that time that device could be on your iPhone or Samsung, and this bill would allow that if it could be delivered appropriately via telemedicine, you could get it. At this point right now, it's not remotely possible to do that via telemedicine, and

I don't think a payer should pay for it, which is the way I interpret that bill.

But what I love about the bill is it doesn't mean every time a new thing comes to the table, everybody has to reconvene in this room to go forward. So in India, they got eight experimental toys that can be remote, you know, fancy optometry setups. If they work and if they become cost, you know, efficient, maybe they would exist here. This bill would then allow that. Right now, my interpretation is it wouldn't and it shouldn't.

REPRESENTATIVE MENTZER: And what is the insurance industry's interpretation?

MS. KOCKLER: If a provider has a way to do it remotely and they are named in this bill and they do it in person, then we have to pay for it.

REPRESENTATIVE MENTZER: Okay.

MS. KOCKLER: That's what the bill says.

REPRESENTATIVE MENTZER: One more question.

Can anybody on the panel give me a good reason why we should not support a requirement for final regulations to be in place prior to the insurance coverage mandate? Can anybody give me a good argument why the insurance company should be mandated to pay for something before requirements are in place?

No. Thank you.

MAJORITY CHAIRMAN MUSTIO: We'll have that for you.

My statement to that effect is, there should be congruency. And you're saying final regulations, and I think if we read the Department of State testimony, you'll see that they're not going to get into the minutia of standards of care delivered by telemedicine like some other States have done, which is delay the implementation of effective delivery of telemedicine.

So the 60-day, as we have done with other bills in the House, the 60-day temporary regulations, I think we actually in the proposed draft amendment are addressing that issue. But that's a valid point for discussion should we move forward on the legislation.

Thank you, Representative Mentzer.

Representative Kortz.

REPRESENTATIVE KORTZ: Thank you, Mr. Chairman, and thank you all for your testimony today.

Mr. Chairman, I want to thank you again for thoroughly vetting this issue and providing the Members with the opportunity to see this at the various providers.

I myself had the opportunity to visit Penn Medicine, and I want to thank Ann Huffenberger, who I met down there, and the Penn Medicine team for their presentation and demonstration. I was there with

Representative Jordan Harris, and Sam was there. It was a very interesting presentation and a lot of questions that day.

That being said, everybody that I have heard speak today is in favor of telemedicine. You're all in favor of it, everybody -- providers, insurance people. Right? You have all said you are in favor of telemedicine. I have heard that distinctly from all of you, okay?

But I have also heard -- and Sam, I hope you don't mind me picking on you. In your remarks, you state right on here that "we cover telemedicine now." However, we have reached out to Penn Medicine. We have reached out to Geisinger. We have reached out to UPMC. And Geisinger in Danville has almost everything covered. The psychiatry, which Superintendent Cross brought up, for children and for adults is covered. Stroke; wound care; infectious diseases.

However, when I go to Penn Medicine -- and, Sam, you and I that day, you talked and you specifically said they are the gold standard for care. You said that that day, and I took note of that, and yet, they are not covered. There's no coverage for wound care, trauma, stroke, psychiatry -- no coverage. Infectious disease, no coverage. There's a whole list of what's not covered.

So I guess my question is, why do we have

discrepancy across the State where Geisinger is getting covered but Penn Medicine isn't; UPMC Health, very little. We have inconsistency. Is there an answer for why we have inconsistency in the coverage of telemedicine? Can anybody give me an answer to that?

MR. MARSHALL: I think some of it is the dialogue, and if there's a breakdown in dialogue between major providers and insurers, then that needs to be addressed. It doesn't need to be circumvented or avoided; it needs to be stimulated and enforced.

Because when we went and we were both at, a bunch of us at Penn, we were all there, and they said, you know what, with national insurers, you guys don't, you know, we don't even, we haven't even really discussed it with you thoroughly, because you know what? We don't think you're covered in other States, and you're not going to create an exceptional situation here.

And we hear, well, you know, in 38 other States, you know, that there's parity or there's all this and that and we do cover it. I don't know which is which. But obviously -- and after that meeting, I sent the materials that were distributed there and asked our companies and said, here, are you talking to, you know, Roy was the one who handles all that, coordinates that for you. I said, here, are you talking with Roy; reach out. He seems like a

reasonable fellow; get in touch with him, and they said okay. Because we haven't had, I don't think on both sides there has been that kind of focused discussion of, hey, let's explore a telemedicine program.

And you're right, and I don't want any other hospitals here to be offended. I did say that Penn was a gold standard. So is CHOP. So is UPMC. So are all the ones actually where the panels went. So is Jeff; don't worry. But the challenge is that our networks consist of more than just those providers.

And the mandate in this bill, you know, whether we call it a mandate, the "shall reimburse" language in the bill, applies to every provider in the network, not just the gold standards but the silver and the bronze and whatever, you know, metal products below that, you know, because we have, many of us have, very open networks.

But I do think that between those who negotiate on both sides, negotiate our contracts with our network providers, there obviously needs to be more dialogue. Some of that is because I think some of the telemedicine programs that you are seeing coming out now are relatively new. I mean, when I say relatively new, I mean a year old or 6 months old or just coming online.

So, you know, everybody needs to come to grips with that. And, you know, that's where the discussion

needs to be had. I mean, I think, you know, we can all have it, and that's fine, you know, if you want to put it in legislation. But ultimately, you're going to have to have the medical directors and carriers discussing this with the medical people within the facilities.

REPRESENTATIVE KORTZ: I understand what you're saying, Sam, but the fact remains, we have inconsistency across this State. Senate Bill 780 is trying to remove that inconsistency. And as you pointed out, 38 States have this already, and we have several States surrounding us. New York, New Jersey, Maryland, and Delaware have telemedicine.

MR. MARSHALL: And you know what, Representative? The other States, they don't all do it with uniform language. You know, some States say here, when it's proven to be efficient. Some States say, subject to the terms and conditions of a given contract.

But, you know, you're right, there are going to be discrepancies among insurers and among providers. Not all providers are the same. They don't all have -- you know, when we were at Penn, they talked correctly and glowingly about their internal controls that they have implemented on their telemedicine programs to ensure quality. Every provider might not have that same level of internal controls.

REPRESENTATIVE KORTZ: And they're the gold standard, right?

MR. MARSHALL: And so the question is, it's not just discrepancy with those darn insurance companies; it's discrepancy within the provider community. Not all providers, any more than all insurers, are created and they don't all do things the same.

REPRESENTATIVE KORTZ: Okay. Thank you.

Thank you, Mr. Chairman.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Representative Helm.

REPRESENTATIVE HELM: Thank you, Mr. Chairman, and thank you so much for bringing this bill up. I think it's a very, very important bill.

And I want to thank all the testifiers. I think you all gave good testimonies. A lot of thought for us to dig through, and I appreciate you staying. And I hope you will continue to work with this bill, and let's move it.

But Dr. Hollander, you started out by saying "There are specialist shortages in rural areas...." And you all talked about rural areas, but I think you started out by the crux of what this is about.

I represent northern Dauphin County, and there are people in this room that know, I have been in office 12 years, and for all of those 12 years, I have tried to

get a medical facility in northern Dauphin County. And as hard as I try, it hasn't happened yet. I will continue to try. But I even had someone, like from a facility, come to me and say, well, we can't make any money in northern Dauphin County, so we're not interested. However, that doesn't stop me.

But over 10 years ago, a doctor from Penn State Hershey Med -- I'll never forget his name; Dr. Tom Turnwith -- called me and said, come and talk, you know, talk to me and I can tell you about telemedicine. So I'm thinking, 10 years ago, you know, we've been talking about this, and, you know, it is happening. So, you know, I would love to see this bill come to pass.

But I just, you know, I wonder, like, what do rural people, people who live in rural areas, what do they do? I mean, do they get less coverage because they live there? Do they move? So what is the answer?

You know, Doug, you talked about the broadband and it probably doesn't reach a lot of rural areas, which I know people on computers do have trouble sometimes. Their computers go down, so I realize this probably would happen, too.

MAJORITY CHAIRMAN MUSTIO: Representative Helm, would it be okay if we asked somebody from Guthrie to answer that piece of it?

REPRESENTATIVE HELM: That's fine.

MR. HALL: Sure.

So we are incredibly rural, as I spoke before. Some of our lowest rural percentage areas are 72 percent and upwards to 100 percent in the five counties we serve in Pennsylvania.

As far as broadband goes, yes, that is an issue. Broadband continues to be an issue, but it is our issue, and we do work with service providers such as Frontier and Spectrum to try to mitigate that.

So we're working through, how do we increase broadband? How do we bring fiber to the network? And there are grants out there through the USDA and other sections where we have applied, and we are trying to bring that to the network.

But that doesn't change that there is cellular data. So there is cellular data in a lot of these areas, and cellular data is enough to carry a face-to-face conversation. We can use that for telemedicine, and we have used that for telemedicine.

What we see in these rural areas, these patients are driving an hour and a half. I didn't get into the first story where we launched our first telemedicine specialty service 2 years ago. In February, we had a storm hit, and we were getting 6-plus inches. We were supposed

to get another, like, 9 inches. We had a number of patients that needed to see a nephrologist, all right?

So our nephrologist is about an hour and a half away, outside of Wellsboro, Pennsylvania. Two of these patients are diagnosed with CKD4, chronic kidney disease 4; needed to be seen. All of our telemedicine visits were completed, where 23 of our 31 regional primary-care sites were shut down. They had no patients show up. We finished all of our telemedicine patients, and we probably eliminated a hospitalization.

So although these patients would have driven an hour and a half to Sayre, even through the snowstorm, to try to get there, we can bring it to them a little bit easier.

A lot of our population, too, our primary payer mix is Medicare. A lot of these patients don't have cars. They don't have transportation. They don't have ways to get to and from appointments. So this makes it easier on them to keep their appointments, to have a family member drive them locally. Or we offer shuttle services locally to bring that patient to their local PCP office, primary-care office, where we can complete that visit with a specialist.

So rural is difficult, it is a lot more difficult, but we also have the benefit of being

nonmetropolitan statistical areas as designated by CMS, meaning we are eligible for a little bit better reimbursement rates.

And as far as our commercial side goes, a lot of our commercial payers follow Medicare guidelines, meaning that if we have an originating site that's in a HPSA location or a non-MSA site, they will cover all specialties for telemedicine.

REPRESENTATIVE HELM: Any other comments?

MR. FURNESS: Yeah.

Well, I'll simply add for Capital, our app-based program would service your constituents in northern Dauphin County. They would have access to it.

Now, I understand, you know, I'm obviously not a technician, but the idea of cell phone data and broadband is useful in a service site. If you're using your cell phone, my folks tell me that the experiences is uneven if it's less than 4G coverage, which is the reason for the comment.

But just to tell you, your constituents would have access, if they are Capital customers, on our Capital Blue Virtual App on their cell phone or on their laptop from home, which would give them an array of primary-care services, behavioral health, that sort of thing.

MR. HALL: Can I speak to that just real quick, too?

So we have the same app, and we partner with American Well. We have the Guthrie Now app. So we have done about 1,200 visits this year already, and our prescription rate is actually 10 percent less than what it is face to face at our walk-in sites. So we value it.

I mean, and Highmark has done a great job of supporting and helping with this, but reimbursement for us for the direct-to-consumer platform has not been -- we don't get the seat at the table to have that conversation and say, why are we not covering this? Well, it's because it's not an originating site. The patient home is not designated as an approved site for telemedicine, so they won't cover it. So that's where the conversation ends for us a lot of time.

What we---

MAJORITY CHAIRMAN MUSTIO: Is that a CMS regulation?

MR. HALL: That is a CMS designation.

MAJORITY CHAIRMAN MUSTIO: Because that's one of the things -- we're primarily talking here about commercial insurances.

MR. HALL: Right.

MAJORITY CHAIRMAN MUSTIO: CMS, which I guess

their new guidelines are coming out, I think they're broadening those, right?

MR. HALL: Right. But commercial payers follow CMS guidelines for us, so a lot of our contracts follow CMS guidelines.

MAJORITY CHAIRMAN MUSTIO: Right.

MR. HALL: So when originating, they follow for telemedicine.

MAJORITY CHAIRMAN MUSTIO: Right. We're not leading. We're letting the government control our health care.

MR. HALL: Yeah; right.

MAJORITY CHAIRMAN MUSTIO: Yeah.

Representative Helm.

REPRESENTATIVE HELM: I think Dr.---

DR. HOLLANDER: Yeah.

So just to add to your question, and it will take me a second to get there, I spend a lot of time talking at telemedicine meetings and know people in telemedicine that share data with me they probably shouldn't.

I'm actually unaware of any telemedicine program that has a positive ROI, return on investment. And so one of the problems at Jefferson, as we look at going out to service rural communities, is I need to be paying a provider and I need to be paying for infrastructure, and I

can take care of people in your community if I can make breakeven revenue, right? Because your community is probably not coming down to Jefferson and giving me downstream revenue, but we would love to help out.

And so what I say often is, unless I can make this revenue neutral -- i.e., get reimbursement for some of what I'm doing -- we can't do care in communities that aren't going to translate into revenue for us because we have a tremendous amount of infrastructure and staffing costs.

And so this all ties together. And you may not get a medical center in your community, but it should be easy to get telemedicine and the right providers in your community. But there's probably not an institution that doesn't service your community that wants to lose money on doing that. If they got money on servicing their own local community, they'd be better able to do that as well.

REPRESENTATIVE HELM: I mean, I know everybody in business needs to make money, I understand that, and that's why hopefully this bill will come together.

Michael, did you have a comment?

MR. YANTIS: Yeah.

I was just going to add on to that, Highmark, you know, provides coverage in 62 of Pennsylvania's 67 counties. We also provide coverage in West Virginia.

So we have a great deal of experience in promoting access to care in rural areas. And I think it is fundamental for both insurers and providers in those rural areas to be able to work together, not only to provide access but to provide the quality access to it.

And I think this discussion around virtual health is certainly a tool to being able to accomplish that, and I think we just want to make sure that we provide the right framework, the right structure, that will allow Pennsylvania to grow in that. So it's a good question.

REPRESENTATIVE HELM: All right. Thank you.

MAJORITY CHAIRMAN MUSTIO: Representative Quinn, do you have any questions?

REPRESENTATIVE QUINN: Yes; may I?

MAJORITY CHAIRMAN MUSTIO: Yes.

REPRESENTATIVE QUINN: First of all, thank you very much for all the time and attention that we have on this bill. I believe it's exciting, and I can't believe I have become such a nerd that I get really excited about this stuff. But that's what 12 years here does.

We have heard, not that much in this round from the providers. We have also heard that this is covered. Can you give an example, looking broadly, of something that's not covered that you would like to see covered as a provider specific to telemedicine?

DR. BEAN: So I can speak to at least behavioral health.

So behavioral health is a huge need, and obviously we have a huge shortage of psychiatrists, psychologists, social workers across the State to meet the demand that we have now. What we have found, and I'll just speak to my experience, is some insurance will provide coverage, but coverage is dependent upon that policyholder's benefit plan.

So behavioral health or mental health is like having a vision plan or a dental plan or something secondary from your primary, and what we find is we're not being reimbursed for that, and if we are being reimbursed, it's only for a small, limited number of codes.

Really, to enhance behavioral health or to bring in third-party vendors so that we can credential and work on our behalf for our patient populations, we need to be able to create a financially feasible model. We cannot create a financially feasible model if we're paying a psychiatrist $300 an hour and we're being reimbursed 73.

REPRESENTATIVE QUINN: Thank you.

MS. DELEENER: The one area I want to point out, and not speaking just for Penn Medicine but I think for the entire State is, rather than going by specific population, when you just look at the provider and patient established

relationship, somebody that you have already seen in person, you have already had that hands-on touch, this, at this point, is now considered a low-risk visit where we as clinicians, that's what we're trained to do. As a registered nurse, physicians, we know what we can do through video or phone versus in person.

And I think, you know, when you talk about medical appropriateness and insurance medical policies, that area, just broadly speaking, I think is something that the providers and the insurance companies need to look at.

For Penn Medicine, you know, again, where we're using a lot of telemedicine is in that area, established patient follow-up visits. Not to undermine new patient appointments and other use cases for on-demand and access to rural areas, but that is another area that, you know, I think we just need to look at more.

And again, to the great point that Dr. Hollander made, you know, this is, it's just a method of delivery. This is nothing more than that. And that's all it is, so. That's one area I think we would like to see some more.

REPRESENTATIVE QUINN: But when you -- excuse me. Just to follow up on that.

When you explain that this is patients that you already have in the system, your investment in the

telemedicine, from what I understand from speaking to health-care systems that aren't represented in this room right now, is in large part because of the, quote, unquote, "ding" you get for readmittance to the hospital, correct?

MS. DELEENER: Yeah, absolutely, the use of, you know, telemedicine to prevent the readmissions, readmission prevention, and having that touchpoint with established patients, especially, you know, when you think about transitions care and, you know, post-discharge.

So absolutely. I think that is a huge area where it's being utilized and, you know, reimbursement would like to be seen, and again, not just for our organization but the multiple organizations. And I know Ann can speak to that as well.

DR. SAIYED: Let me just add one more thing to the example that Dr. Caicedo mentioned earlier about the MS neurology patients, multiple sclerosis patients that we had to set up very quickly because we had a gap here in the coverage in central Pennsylvania.

If you go by the methods of our insurance companies that, you know, this is all experimental in every service and every specialty and every case, and this was really not even a specialty, but every case you have to prove it to us, we would be left without coverage, which we weren't. We weren't reimbursed, but we wanted to provide

this service to those patients, to those very sick, very complex patients that probably have other sources of disability from their multiple sclerosis, and they couldn't travel. We would not get there, and we didn't get reimbursed for those services.

Does that make sense? So it's every specialty. If every use case we had to defend and we had to prove -- and this is not experimental technology. We have proven there is tons of evidence that this method is proven, it's successful, it's cost-effective, and it provides great quality service.

I mean, I can go down the list of things that were not reimbursed, but it's a long list.

MR. FURNESS: Can you provide that? I would like that. And also if it was submitted and denied---

DR. SAIYED: It was.

MR. FURNESS: ---or not submitted or -- any information you have I would be interested in.

DR. BEAN: Yeah. I could talk about the 4,000 infectious disease consults that we have done without ever receiving any money from the insurance companies. But what I would really like to focus in on is providing---

MAJORITY CHAIRMAN MUSTIO: Doctor, would you do me a favor?

DR. BEAN: Yes.

MAJORITY CHAIRMAN MUSTIO: That word "consult" means a different thing to insurance companies.

DR. BEAN: I apologize. Thank you.

MAJORITY CHAIRMAN MUSTIO: And consults between physicians are specifically not covered---

DR. BEAN: Thank you.

MAJORITY CHAIRMAN MUSTIO: ---or are not anticipated to be covered in the bill. So if you're talking about a visit, say that. But if it's a physician-to-physician consult, that's a totally different animal.

DR. BEAN: I apologize. It's common vernacular.

MAJORITY CHAIRMAN MUSTIO: I'm only going to correct you once.

DR. BEAN: Yeah.

MAJORITY CHAIRMAN MUSTIO: I'm just kidding.

DR. BEAN: So for the 4,000 visits that have occurred from our infectious disease specialists that decreased the number of transfers and saved antibiotic costs and kept people in their towns, what I would really like to talk about and what I would like to get paid for is what makes sense for the patients and what makes sense for the physicians: that care that is provided where the mother, the single mother that has a sick child at home, does not need to get in that car in snowstorms to drive in

to be seen.

I think telemedicine makes sense in a lot of cases, and unfortunately, a lot of it is not paid for. I think if it makes sense for the physician, and what makes sense for the insurance companies and what makes sense for the patients, really, that's my telemedicine Triple Aim.

REPRESENTATIVE QUINN: Thank you.

Doug?

MR. FURNESS: Can I ask a question?

Doctor, the question I have, and we were together---

DR. BEAN: Yes.

MR. FURNESS: ---down at that facility with Chairman Mustio, and we had an infectious disease demonstration. And I recall the comment was, we don't bill for this.

DR. BEAN: That is correct.

MR. FURNESS: Okay. So the question is for you, are you billing now? Because my people tell me that's not happening and that they are willing to and eager to work in concert with the providers from that region.

DR. BEAN: Sure.

Yeah. We have had the discussions with insurance companies. As a matter of fact, about a month ago we sent surveys out to 12 insurance companies that cover our area.

Of those 12 insurance companies, we received feedback on what is actually, specifically what is covered and what is not covered. In that month, we received two back. This was followed up with two phone calls and follow-up to receive any kind of comment, and we have heard nothing.

So your question was, are we now submitting them? Yes, we are. Sadly, we have to now prove. Our word is not good enough. We now need to prove that it's not covered, and that's what we're doing.

MAJORITY CHAIRMAN MUSTIO: And I think---

REPRESENTATIVE QUINN: Thank you.

MAJORITY CHAIRMAN MUSTIO: Just one of the things is, as we went and did the tours across the State, the overwhelming response was, when we asked specifically, because the insurers were asking for this, you say we're not paying, but we're not getting any denials, right?

So I asked that question. The first place was at Lehigh Valley, and they said, well, we're not billing because what's in this binder says it's not covered, so why would we bill for something that's not covered? And I said, because you have incurred a cost, and if they're not going to pay it, send it to the patient. And I'll tell you what; you start getting all these patients that are coming to their State Representatives and their Senators, this would have been fixed 6 years ago. But that's not how you

do it.

And the response from the provider was, we eat it. We do it because it's right. It's the right thing to do, but we can't necessarily now afford to implement new programs or in the margins, if you talk to Lehigh Valley, sustain the ones we have. So that was it.

Representative -- oh; I'm sorry. Doug, do you have a follow-up, and then Representative Quinn.

MR. FURNESS: Yeah.

The only thing I would add is, we surveyed the health systems in our service area, and what we were told almost consistently from all of them is that they weren't billing for these services not because they weren't getting reimbursement but because they viewed it as a value-add to the services they were already providing to the customer.

So the reason I bring this up is, you know, if insurers are being accused of not paying for these, we really need to know that we aren't. And if you're not billing them, we can create a dialogue outside of the legislative process to do that. That's what we do now.

MAJORITY CHAIRMAN MUSTIO: Well, and I would agree with that statement. But the value added is really a broad statement without listing specifically those services. Because when we took the tour at Lehigh Valley,

they said, we don't expect reimbursement for this. We were down at CHOP: We don't expect reimbursement for that camera in the room; it's just, that's providing goodwill to the mom when she's at home in Montgomery County and she can see her baby in intensive care. They're not expecting reimbursement for that.

What they were expecting reimbursement for is when the physician, the infectious disease doctor or the neurologist, is in the patient's room and it's reimbursed, but because of the shortages of those physicians, and they have to visit, come to them via telemedicine, that's what's not being reimbursed. That's why there's so much red on the sheets.

That's where I personally have a problem, and it seems like a lot of Members of the Committee probably have a problem. But I am very sensitive to what your concerns are about putting the fence around. Absolutely. And we're trying to work on the language -- right? -- and that's where some of this frustration level is.

And I feel like this is like when we threatened liquor privatization in the State, right? Now all of a sudden we have wine in the State stores. Now you guys are talking. Where have you been?

REPRESENTATIVE QUINN: Can I get back to my questions?

We're always told, don't ask a question you don't know the answer. I don't know the answer to this, so I might look like an idiot. But I could only assume that payments, reimbursements to providers, is congruent with cost-of-living in different parts of the State. Am I correct?

I see a nod. So reimbursement in Clarion County may be different than a reimbursement in Bucks County than in Philadelphia County. What is the model presently for where you reimburse? If I'm in Clarion County and I am referred to a physician in Philadelphia County, are you paying off of the reimbursement rate there at the higher level or where I'm standing in Clarion County?

Because it's dawning on me here that some of the concern may be, holy smokes, we're blowing the lid off actuarial projections for payments if we open up reimbursements for wherever our top docs are perceived to be. As we called it, gold standards of care versus others.

MR. YANTIS: I'll take a first shot at this, but it's going to be very general, because we're getting into what I'll say is the nuts and bolts of the reimbursement arrangements between insurers and providers, and it's well beyond my knowledge.

But generally speaking, your statement is accurate. Reimbursement does include a geography factor.

You know, I don't know what that factor is, I don't know how much it differs, but there is a difference.

Now, your specific question in terms of the originating site versus the site to which you are beamed to the physician and the care occurs. Generally, that's going to depend on a variety of factors, and at the highest level, it's going to depend on what the reimbursement arrangement is between the insurer and the hospital where the individual is, the relationship between the hospital and the site to which they are beaming the care to, because in some instances, that relationship will be between the two providers. They will have an agreement worked out to cover the cost of that, where the insurer pays the bundled payment to the originating site; in other instances, it will be different.

So that's a long way of saying, I think it's going to vary depending on the reimbursement arrangements that the insurer has with the providers, because they are different. They are significantly different, particularly when you're dealing with health systems, from health system to health system.

Does that help?

REPRESENTATIVE QUINN: It confirms that it's confusing and it's complex.

MR. YANTIS: Well, I can definitely confirm that.

Yes, it is very confusing.

REPRESENTATIVE QUINN: But I do come back to my original---

MR. YANTIS: Yeah.

REPRESENTATIVE QUINN: You know, is it a concern of the insurers that suddenly projections for payments are blown, because I could be receiving behavioral health, not sitting in a hospital but sitting in my living room, and the person that's delivering that care to me via telemedicine might be in a higher payment reimbursement area or a higher reimbursement contract.

MR. YANTIS: The short answer is, yes, it's a concern, particularly when we begin talking about a legislative or a regulatory construct or framework that not just tells us what to cover but how to cover it and how to design those reimbursement arrangements.

I think generally speaking, again, Highmark's coverage of virtual health is robust, so we're used to doing this. We have these negotiations. We have these discussions with providers. We're making it work. If we're going to begin to define and regulate how those nuances of those arrangements work, then it does become a concern, because it may not address the differences between provider and provider.

REPRESENTATIVE QUINN: Okay. And I believe this

is my final question.

When -- I believe.

When we talk about the skeleton, the foundation, and the guardrails, and when we talk about the confusion that you have, that we're looking for clarity in this Section 6, whatever, that it says all services must be paid, don't you already have the ability to put those guardrails in with tools such as prior authorization and reimbursement rates that you negotiate with providers?

MR. YANTIS: Yes. I'll be very brief. I'm not trying to monopolize the microphone.

The short answer is yes. There are controls in place in that. What Highmark and AHN is concerned about is the specific language that ties it and requires the coverage and reimbursement because it's an in-person setting. We think that's an incongruent parallel to draw.

We're talking about virtual health, the delivery of care that is going to far outweigh -- if we're sitting here 5 years from now, we're having a much different discussion about this issue. So it shouldn't be, it shouldn't be -- I would say that's constraining in one sense to connect it to that in-person setting, and I think from the provider side, and Betsy, you can kick me on this one if I'm wrong, but I think you can accomplish the goal of providing a wide requirement for coverage without that

connectivity -- no pun intended -- to the in-person setting. And I'll pass it on.

REPRESENTATIVE QUINN: I think you took my question off guard. What I was saying -- I mean, off line.

What I'm saying is that if there's a problem for reimbursing -- for example, the setting of the broken leg -- can't that just be a, no, we don't reimburse for the setting of a broken leg via telemedicine?

MR. MARSHALL: The challenge, Representative, is that the bill says that we have to have the same standards of care and rules of practice for telemedicine that we do for in-person. And so the question is, how does that guide us as we try to set up guardrails or parameters if it has to be the same standards of care for both and we don't think that they necessarily will evolve that way? That's a challenge.

And, I mean, it goes to one of the underlying questions. You know, Dr. Bean mentioned that he didn't get answers, so I'm going to ask you afterward who, because I'm going to check up and get them to answer you.

But one of the things, you know, we hear is that insurers and hospitals or, you know, providers aren't talking, and I guess it has been said that we're not answering, you know, their inquiries. And this bill, the problem that we have with this bill -- I don't know that

that's true, but the problem with this bill is it doesn't force a dialogue. It overrides any dialogue and just creates, hey, you know what, there's no discussion; you just pay.

REPRESENTATIVE QUINN: But don't you have the ability to override that you just pay by putting in your hurdles of prior off procedures?

MR. MARSHALL: Yeah.

REPRESENTATIVE QUINN: I'm not trying to be difficult, you understand.

MR. MARSHALL: No, no. But that's why I raise it as a question. I mean, if we don't have it for in-person, can we still have it for telemedicine? You know, can we have unique quality controls for telemedicine that might not be applicable in an in-person setting? Those are the questions that we have about what this "shall reimburse." You know, the way we read it is, it says we shall reimburse for telemedicine if we do so for in-person, and we have to have the same standards of care and rules of practice.

So going to your question, I don't know under the bill what we can and can't do. You know, that's why we say maybe, maybe not. And all I know is that we ought to figure that out beforehand, not afterward.

REPRESENTATIVE QUINN: Doctor?

DR. HOLLANDER: Yeah.

I think this gets so much easier to understand if we just go back to sort of my opening comment that telemedicine is just a care delivery mechanism. If somehow I could set their bone through some waves that I sent to them and their bone is set appropriately in the right spot, it should be covered. If I can't do that and I can't take care of the patient the way they should be taken care of, it shouldn't be covered.

It doesn't actually matter how. It doesn't matter whether it's on the third floor or the fifth floor or in their living room or where they are. Care is care. And I think if we just focus on, care that is delivered appropriately and is high-quality care should be reimbursed if it's reimbursed when it's in-person care, and we're done. Everything else falls really and neatly into the package.

If I do something that is malpractice, I do something that is malpractice. I could do that in the emergency department with all the constraints in the world. So the guardrails are there.

What makes this confusing is the word "telemedicine," and if we just take that out of it, we'll get the concepts right. And then we can decide, well, geez, there's no way right now in 2019 you can do fancy neurosurgery via telemedicine, but you might be able to in

2025, and this bill would then cover that. Maybe it's 2055.

But I think, you know, that's an easy concept to grasp, and we keep getting caught up treating telemedicine as something different, and it's not; it's medical care. No one said, I'm incapable of using a plastic stethoscope so the visit doesn't count; I need to use a Littmann cardiology $350 stethoscope. If I listen to the heart and hear what I need to hear, that's good enough.

No one monitors the forceps I use, well, I don't, but that a surgeon would use during surgery and don't pay for a well done, quality surgery because they used a different instrument. Telemedicine should be the same thing.

REPRESENTATIVE QUINN: Thank you, Mr. Chairman.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Representative---

MR. FURNESS: Can I offer one more?

MAJORITY CHAIRMAN MUSTIO: Let's get the questions asked. And absolutely; I'll stay here all day to get it on the record.

Representative Mehaffie.

REPRESENTATIVE MEHAFFIE: This has not been easy. I truly appreciate what we did on Friday and you being the guinea pig during that telemedicine, when we did that and

we had that little seminar at the community center down there.

But I think my main question is, and it seems to me when hearing the questions and what you guys have given us so far is, we don't want to create something that creates inferior health care, okay? So I guess one of my friends said to me, this thing is not quite baked yet. And I think that we're headed there, we're getting there, and I think things are where we need to be, but we need your help.

But the question I had, because when we were asking questions on Friday when we were down at the other medical center down there, the question that was asked is, does this get reimbursed through Medicare and Medicaid, and they said yes, but it is at a higher rate.

So do you feel that this bill as it is today will cost our health care to go up in price? That's the first question.

Stumped the panel.

MS. KOCKLER: So Medicare and Medicaid cover what I would say, like all of us, they don't cover everything. They don't cover everything via telemedicine. So I would ask we take a deeper look. I don't know what they do and don't, but I don't think it's a blank check either, because they're public programs with limited dollars.

So I just, I do think that we do need to put the tighter reins around this. And I'll just say, we're sitting here today with big hospital systems for the most part. We're not talking about the individual practitioners who will be able to do this and bill away as they see fit. They're a part of this. They're going to be part of the utilization. They're going to be part of the cost equation.

That's why we are saying -- and I know other States have passed different laws. But again, I think the deeper look will show you, they haven't named providers like this bill does. I don't think you'll find any State that has done that.

So we really need, we do need to rein it in in our opinion and make it a little tighter. It's not a bad thing. It is something we're working toward. But to your point, yeah, Medicare and Medicaid cover it. It's not carte blanche.

Maybe look at their guiderails. I don't know what they are.

REPRESENTATIVE MEHAFFIE: I don't know that, what their guidelines are. I know when he mentioned, the doctor mentioned about what the reimbursement rate was, he said, yes, we get reimbursed more for telemedicine than we do for an in-person visit.

MS. KOCKLER: Right. And I think that's actually the benefit of why this needs to stay the discussion between the provider and the insurer and not be, you know, set in such tight guidelines, tight boxes.

There will be gaps in coverage where, yes, we might be willing to pay more than we would in person. That could certainly happen. But the whole goal of telemedicine, as everyone knows, the doctors have said it, is to do it more efficiently for that patient, probably save some money, and certainly save that physician's time.

So it has that potential. It definitely has that potential. But it's going to be, again, a yin and a yang. If there's a gap in care and we need more behavioral health folks -- we're actually going into telebehavioral health in 2019, because we know there's stigma. It's more convenient for folks. It's going to improve care. But, you know, there will be some areas where there's gaps in care where providers will be paid more. So we don't want to lock it in.

MR. FURNESS: Just to echo Kim's comments on that, we have a behavioral health product now through our app-based system, and we reimburse at the same rate as we do in person because of the demand and the importance of it.

And I think Kim is right. This will work itself

out if left to its own device, and we may very well pay more services at parity, or more, that our customers demand. I mean, that's just the way the system is working now.

REPRESENTATIVE MEHAFFIE: Thank you.

Yeah; the concern that I think all of our constituents statewide are experiencing is the cost of health care. It's coming to the point where it's not affordable, affordable either through their own payment or affordable through their employer.

And, you know, I hear it constantly in my district, and this is something that if we're going to drive the cost of health care up because of this, then we got a bigger issue out there. I mean, but if it's going to work its way out, I'm okay with that.

I love it. I think it's great. It's cutting edge. We need to get there. We need to be there. You know, this is one bill out of many that we have to make sure that, you know, our constituents and the patients have adequate health care.

And you're right; when you go out and you meet with a specialist, it could take you 6 months to see them. If this is the way to get in there within a week, I'm all for it. But then we also got to be careful that we balance this whole thing out and we don't make sure -- or we make

sure, you know, that this isn't driving costs again through the roof, because we just can't sustain it.

DR. HOLLANDER: So I didn't go over all the data when I spoke. I went over some of it. There are a bunch of cost analyses. They all, with one exception, show saving money, as far as I know.

You know, the States that have passed this, they may have amended their bills over time, but no one is throwing their hands up and saying, oh my God, we can't do this. The reality is, I know the numbers from many, many places, particularly my own. We lose a boatload of money doing this.

And our challenge, and I'll tell you -- and this is, I guess we're on tape, so it's not as confidential as I might want, but I think it's important to say. You know, Jefferson has done a bunch of mergers and combinations in the last couple of years with different health systems. One of the health systems grew telemedicine to the thousands of calls a year. Then they looked at their reimbursement. They'll probably do 150 calls this year. The patients loved it. The providers loved it. It went away because it's not paid for.

It doesn't make sense. Reimbursement is preventing this from growing. We collected 10 cents on the dollar for each call that we did at that enterprise.

Another one is doing virtually no calls. Our mothership is doing great. Volume is going through the roof, but it's not reimbursed. We're just committed to one day it will be reimbursed and be near breakeven.

But it is a money loser, and it is a money loser everywhere. So, you know, we're investing in doing this because it's the right thing for the patient and it's really good, but it just is not tenable to go forward for 5 or 6 more years while we negotiate slowly around a table without putting some constraints on it and giving it a foundation and a framework to go forward faster.

But I think seeing costs go up is not something people have been seeing.

REPRESENTATIVE MEHAFFIE: Great. Great.

Thank you, Mr. Chairman.

MAJORITY CHAIRMAN MUSTIO: Thank you, Representative.

The second round, we have Representative Christiana and then Representative Day.

Representative Christiana.

REPRESENTATIVE CHRISTIANA: Thank you, Mr. Chairman.

I have a few more questions for the insurance community. But before I start those questions, I just want to say it's hard to ask questions on the bill's language to

those testifiers that support the bill as drafted and recommend passing it as drafted. So my questions have been and will be focused on the insurance community, and it's because you have legitimate concerns. You have legitimate concerns that I think many of us want to address and try to find a solution that works for everyone, whether or not that's practical. I just wanted to state that it's not to be antagonistic. It's to try to reach the best bill and to hear your side and see if there's a legislative solution.

And so once again as I selfishly plug my Senator's leadership, Senator Vogel, on prime-sponsoring this bill, significant health-care reform, Senator Vogel wasn't an innovator, as it has been said. This bill is not a new concept. Thirty-eight States have some type of uniformity language, States like Texas, Georgia, Mississippi. Also States like California, New York, and Vermont.

Needless to say, this is not a conservative issue. It's not a conservative health-care issue. It's not a liberal health-care issue. In my opinion, it's a patient centered health-care issue, and those States, I think, reflect how a lot of people feel. Republicans, Democrats, there's a lot of frustration. And in a State like Pennsylvania that has the geographic diversity that we have, there's a lot of inconsistencies around the State.

So I commend the Chairman once again. I didn't in my opening comments, but I commend the Chairman for his leadership.

And I think it was appropriately described that the health-care provider and health insurer relationship is terribly complex, exceedingly complex and complicated. Yet, this bill is being criticized for being too broad, for providing too much flexibility, for allowing the health insurers and the providers to navigate that tremendously complex relationship.

One of the solutions was that before we solve these issues of these ambiguities or these broadness issues on price, on services, further defining providers, further providing specifics on those issues, it was recommended that we do those things before we pass it rather than after. But my concern there is, that means we are legislatively addressing those issues, that we are further handcuffing the complex relationship.

And those issues, while they're not legislatively addressed, they are addressed. They're addressed in contractual relationships, contractual obligations. They are addressed in the private sector that we heard is doing this already in some instances, and successfully.

So what I'm seeing is, you have the solution. It just needs to be broadly applied, and it's not, and that's

the problem I think we're trying to solve.

It was characterized -- you know, the question was, can you reach these contractual obligations or these contractual relationships and these terms on these ambiguous issues within 90 days? We have already reached -- you bragged, in a good way, of how you have already reached those terms and this is working in some instances. So I don't think that the legislation is asking you to come up with all the terms from the ground up. The relationship exists.

These terms, these obligations, this ambiguity that will be fixed in the private sector rather than legislatively will get fixed. And I don't think that us addressing, let's just say the price issue, by doing what other States have done and handcuffing you with parity legislation is the best solution. But I almost feel like that's what's being advocated today from the insurance community, implicitly saying, let's address these things now. Let's clear up all the ambiguities.

I mean, you're not obviously advocating for parity payment, because that would provide you with the predictability, but that would further limit you to work out those agreements with the providers, correct?

MR. MARSHALL: I'll take the first shot.

The questions that we raised with respect to the

ambiguities we find in Section 6(a) aren't things that we think we can -- we don't know if we can do them. As I mentioned, I don't know if we can say, hey, we're going to have prior authorization for telemedicine that we might not have if it were delivered in person. That's a question. Is that what's intended in the bill, or do we still get to have that or don't we? That's a question.

I don't know that we can say, here, we'll have different payment levels for different providers within our network when they're doing telemedicine because we think some do it at a higher quality level than others.

I don't know if we can say, not all providers. And, you know, Kim mentioned here that we're dealing here with the mega provider. You know, Representative Kortz referenced, you know, the gold standard. But there are a lot of other providers in our network, and this would extend equally to them.

So those are sort of some fundamental questions about how far does this "shall reimburse" any participating provider go. You know, those are things that we ought to resolve now, because otherwise we're going to come back and we're going to say, we read it this way, and some provider is going to say, we read it that way.

The one thing I would note, going to, you know, what you started out with, and it has been a frustration

here, we're all about saving money. We're all about holding down rates for our policyholders. You know, rightly or wrongly, yes, we care a great deal about quality, we care a great deal about access, but we're also under very strict controls to hold down costs. If we thought that this was going to reduce insurance premiums, we'd be the ones advocating it, all right?

You know, that's where if you take the dialogue out, that our concern is that when you remove the dialogue -- and that's the way we read Section 6(a). When you remove the dialogue that goes on between the insurer and a network provider, our concern is that by removing that dialogue, you're taking away our ability to have any involvement in ensuring that it's going to be quality, access, and cost-effective.

REPRESENTATIVE CHRISTIANA: What we're taking away in this bill, as I read it, is that what is not negotiable is covering a telemedicine appointment. It's not--- Yes, that comes off the bargaining table. That can no longer be negotiated. That power has been legislatively determined.

MR. MARSHALL: Correct.

REPRESENTATIVE CHRISTIANA: Yet the price, yet the rest of your contractual relationship as it relates to in-office visits, as to who's in your network, like I said,

"medically necessary" does also deal with frequency.

There is this -- listen, I don't think any of us want to raise the cost of health care. And when we talk about overutilization, I mean, that's great that people are getting more care, which I think is wonderful, but we're all concerned about cost. So when the insurance community says, we're worried about costs going up, yet you are limited, the providers are limited by what's medically necessary, that also addresses frequency.

So every time I check my electronic health record on my phone, they can't reimburse for that because it's laid out what is medically necessary and has to be consistent with their contractual relationships.

And so I guess my overall concern maybe for the next few days as we move forward and in this session, rather than maybe highlighting the concerns, if we could provide some solutions to these ambiguities, this broadness, because I ultimately think if we were to put in an amendment to take away the payment issue, the rate issue, how much they're paid, and put parity language in place, I think the insurance community would oppose that.

And so I guess all I'm hearing is a lot of, a lot of problems this morning but not a whole lot of potential solutions and whether or not a legislative solution is the best solution. Because these issues won't evaporate; they

will just move to a different forum -- in a conference room, at the bargaining table, hammering out the details. But what will not be leveraged and cannot be negotiated is coverage.

MR. MARSHALL: Yeah. But, Representative, one of the things that you mentioned, we have said, and I think we have said here today and I know we have said it in the past, we agree covering -- you know, we cover telemedicine now. If people want to talk about expanding it, we're fine with expanding it on services and all of that. But the problem that I have with where you're going is what the bill says, if we read it, is that we have to cover telemedicine provided by a particular provider and we would pay that provider as if he did it in person. So it makes it on a very case-by-case---

REPRESENTATIVE CHRISTIANA: And it's medically necessary. You leave out those other controls, though.

MR. MARSHALL: But you know what? But what -- I mean, it's probably worth an aside. This would be a longer conversation than what I think Representative Mustio wants us to have.

But the challenge is, with each and every provider, you know, Judd talks about this is really a question of the setting and, you know, telemedicine is just as equal. It isn't for every -- we don't think that it is

for every provider and for every service always the right setting, and what we want to be able to do is work with our participating providers and work that out in negotiation.

If we're not returning phone calls, I'm going to yell at people who aren't. Because as Kim mentioned, we regard all of the providers here, all of the hospitals here, we regard them as our partners. I mean, you can't do business up in the Lehigh Valley unless you have Lehigh Valley Health. You can't do -- I mean, you'd be hard-pressed to have a good network if you're not a part of the team, if we're not partners, and that's where the discussion needs to be had.

REPRESENTATIVE CHRISTIANA: Thank you, Mr. Chairman, and thank you for your patience today and your involvement.

MAJORITY CHAIRMAN MUSTIO: Representative Day, do you have a follow-up question?

REPRESENTATIVE DAY: Thank you, Mr. Chairman.

Again, I really appreciate everybody's time here today.

I guess I would just like to make a statement and say that as I listen to everything, a lot of my concerns have been talked about. The insurers have talked about a lot of things that I worry about. The providers talked about providing great service for patients. Also, the

provider-insurer relationship is the most professional, you know, integration.

And the gentleman on my left over there, I'm sorry, I don't know your name, but the information that I asked for, if you have that, provide it to the Chair.

And, Mr. Chairman, I usually look at legislation as a solution, and in this case, I really -- I understand it enough to know how complicated that negotiation is between provider and insurer. But if that gentleman would provide that information and the insurers would balk at covering it after there is proven data that a service works -- outcomes, costs, everything is hit -- then I think we need to move to a legislative solution.

I'm not totally against being in support of your legislation now either, but I just want to make that statement, because that's usually where I am.

Also, I understand that providers are trying to provide health care, not accumulate data and try to advocate from a position, you know, spend all their time doing that, so I understand we might have to just do this legislation now. But that's where I usually start from, and I would really like the opportunity that if you have that data, get it to the Chairman. Push it to them and challenge them to deny or approve that and see what happens. It's a great opportunity for us to see in a

microcosm the overall wide swath that we're going to be trying to do with one broad sweep of legislation here.

And finally, what I would just like to let the Chairman know is, I would appreciate, I don't know how you would send X-rays, as you said, to set a bone. I don't know how you -- we talked about it last week -- how you press on the stomach and determine kidney, gallbladder, or something else in the trunk area of the body.

MALE VOICE: YouTube, Gary.

REPRESENTATIVE DAY: YouTube. (Laughing.)

I don't know how you do that. And dental hygienist was in some of our things. I don't know how you clean teeth with telemedicine.

So just my ignorance, I would need to have a couple of those answers for my constituents, that if I vote on something like this and there's something out there, hey, Gary's letting all this type of stuff go on, I would like to be able to explain it to my constituents. Not necessarily am I advocating for it to be included in the legislation, but it's just something in the process that I would like to understand.

So the first comment about, and I think it's very important to just underline a couple of times, the provider-insurer negotiation is vital to the overall cost of health care. I think both entities are vital, extremely

vital, at provisioning great services and then working through that.

And it's important for us to have a policy that we don't necessarily shift, you know, authority one direction or the other. And I think we have established, right now, the insurers have the lopsided authority, and this legislation might tilt the lopsided authority on this issue to the providers. And I just really think we should be very careful how much we shift that responsibility.

Thank you, Mr. Chair.

MAJORITY CHAIRMAN MUSTIO: Thanks.

Representative Kortz.

REPRESENTATIVE KORTZ: Thank you, Mr. Chairman.

And again, thank you all for your testimony today. More of a comment than anything.

And Dr. Hollander, you started it today. It really caught my ear, telepsychiatry, and it was followed up by Superintendent Cross with her very detailed explanation. And I was reading through some of the incidents with the children. Lord knows, a lot of our students today have a lot of problems.

And I want to couple that with, I was at a hearing in Philadelphia just several weeks ago. Representative Kinsey had a hearing on community violence, and it was interesting because the Assistant District

Attorney was there. Everybody was talking about the violence, and they had several people talking there that had lost, they lost their sons. And the one woman was talking about how it affected her younger son and he wouldn't go to school, and there was people there from the school saying, we don't have the specialists in our schools; we don't have them to deal with this to talk with the children.

So I was thinking of this the whole time when you were talking about it, Dr. Hollander and Superintendent Cross, that this would be a great tool to try to capture some of these young students that experience violence, wherever it is in the State. But right now, we got a big problem in Philadelphia with all that's going on there. And that was a very eye-opening hearing that I attended and the people talking about, from the school district, we don't have the right specialists in our schools to help give guidance to these children.

So this is an excellent opportunity to maybe reach out to these impressionable students, to get them on the right path, and help guide them through a traumatic experience that happens in their life.

I just wanted to make that comment, because I wasn't expecting that today, but I was glad to hear it. And that's why I was looking through here who is covered

for telepsychiatry and who isn't. But thank you for that information today.

Thank you, Mr. Chairman.

MAJORITY CHAIRMAN MUSTIO: Thank you.

Any other Members?

I just have one quick question for Allegheny Health Network, and I guess Highmark as well.

Allegheny Health Network gets some reimbursement to support, as you said earlier, from Highmark, but that's really having Highmark underwrite the program. How does your recommendations and proposal help those hospital systems that aren't integrated? How does it help them get reimbursement?

MS. TAYLOR: Well, so to be very honest about it, I think prior to Highmark and AHN forming Highmark Health, maybe Highmark wasn't as robust of a payer as it is today. And to the other insurers' points, it was through a lot of negotiations and sitting down and actually talking and having a dialogue to see that there was tremendous value in the program that AHN had put together for telehealth.

As a result of those discussions, Highmark Inc then broadened its reimbursement policies. But they're not just unique, as I said before. The payment is not just for Allegheny Health Network. It's for any contracting hospital or health system or provider within the Highmark

provider network.

So the knowledge that was gained between our relationship and dialogue is now transferable to all the other providers. And that's what we would hope would happen elsewhere. Unfortunately, it's not good public policy to legislate that kind of process.

And our particular problem, and we have stated many times before that while we are very appreciative of Highmark's payment, we can't sustain our telehealth program with one payer. We're very fortunate to have Highmark, but we need the other payers to come to the table.

And with all due respect, we don't have that dialogue with all the other payers. We're cut off initially at the get-go by directing us to another platform or a vendor, and that's the only way they will reimburse for those services. And quite frankly, when you have developed your own platform, you don't want to put out a licensing fee of $400,000 to participate in someone else's, especially when we think ours is pretty superior, to be quite frank.

MAJORITY CHAIRMAN MUSTIO: What are the others? You're talking about Amwell and Teladoc, right?

MS. TAYLOR: The national. Mm-hmm.

MAJORITY CHAIRMAN MUSTIO: Because I think that's what's in Highmark's policy.

MS. TAYLOR: Mm-hmm.

MAJORITY CHAIRMAN MUSTIO: So explain to me the process then. How does the electronic medical record for that patient get updated using Teladoc or Amwell?

MS. TAYLOR: There are times when it is updated, but most times it's not. So that's one of the benefits of our platform, that we have an integrated medical record. We use the Epic system.

We're also partnering with other health systems, not just within AHN hospitals, to get interoperability with other platforms like Cerner. But the Teladocs and the Amwells do not integrate into our platform.

MAJORITY CHAIRMAN MUSTIO: So how will they upgrade -- how are they updated then? How is the electronic medical record updated when it is updated for that patient?

MS. TAYLOR: Um, that I'm not completely sure. I think it's just scanned information, and if we get it -- sometimes we get it. If not, the physician doesn't get it and we're not able to connect it to our platform.

MAJORITY CHAIRMAN MUSTIO: It's my understanding that it's hopefully sent over. But this legislation requires that update to take place in 24 hours, so that information will be required to be sent. So if Amwell or whatever other insurers you're talking about are using

Amwell or Teladoc and that information is not being updated for the patient, and it makes sense, right? So if they're treated for something and then their physician wants to see what the most recent maybe situation was or the prescription that was made and that's not updated in the system, then that's a failure, right? So that's a concern. And that, to me, is in addition to the costs, right?

There should be, as I have heard earlier here today, competition, right? The marketplace, some competition. So it seems to me to make sense that we not restrict payment for a system that has their own developed app that integrates with their electronic medical record that's going to compete with an insurance company's contracted program with Teladoc or Amwell that's being forced on you, is what I'm hearing. Either you do it this way or you don't, even though it's inferior from a medical records' standpoint, right?

So I think that's something that as a committee we need to look at. And we have ample information, as we have heard from insurers, on how particularly the handheld saves emergency room visits. And in some cases, that's probably an increased utilization, right? A member might not necessarily take the time to go to the emergency room if they can do it over the phone. So that's increased utilization.

I mean, just take that by itself. If an insurer says, oh, it's going to increase utilization, oh my gosh, but you have got to hear the rest of the story. So because they were treated, they didn't have a more serious condition that was going to be more expensive.

So as Members, when we get these letters and emails -- and we get a ton of them in favor of the bill. But we're going to continue to get hypotheticals and what-ifs, and we need to cut through all that. That's what the last 9 or 10 weeks was all about. Let's get down to the specifics.

Think about it: If we just sat in our offices in Harrisburg, had a hearing here, never went out to see in person what was going on, we'd have two sides saying certain things and our eyes would be glazed over. But we actually visually saw and heard stories, saw patients, and Representative Christiana and Representative Readshaw have talked about those. So that's really a positive.

But I don't want to see legislation passed that is legitimately going to cause problems. If it's just going to say, these what-ifs might happen, we don't know, then the side making those arguments, in my opinion, after all these years of doing this, isn't really, as Representative Christiana said, contributing to that dialogue, particularly when, as he mentioned earlier, or

I'm not sure he's totally aware of that, but some of that same language was suggested by the Insurance Federation, yet for some reason now, we don't know what that is.

So we need to get together here, and as a committee, we'll decide whether we're going to move this bill.

But I think the providers have heard some questions and concerns. There is some information that has been requested by Members, legitimate information, so anything you have from a cost standpoint.

Highmark, are they a large insurer? I think you're pretty large, right?

MR. YANTIS: Yes.

MAJORITY CHAIRMAN MUSTIO: So think about it. Think about, if you're a Member---

MR. YANTIS: I thought it was a trick question. Sorry. Yeah.

(Laughing.)

MAJORITY CHAIRMAN MUSTIO: Think about it as a Member. You're sitting up here, and we just heard Highmark and Allegheny Health Network were able to expand the use of telemedicine, yet we heard insurers say, we don't know if there's data that supports all this. It seems to me, like, maybe just call somebody in the 412 or 717 area code and start getting that information.

If you truly are committed, as some of the information we have gotten, really committed to telemedicine and we want to support it and all this stuff, I think there's ample resources, right? At least from what the Members have heard. I would doubt that even those that may have questions or oppose it would challenge the fact that we're looking at this situation here. You're looking at Highmark or looking at -- boy, that was a Freudian slip. UPMC and UPMC Health Plan or Geisinger and Geisinger Health Plan, somehow they're making it work.

Yes?

MS. KOCKLER: In all due respect on that, those are integrated systems where it works differently. They're paying themselves. They're their own entities. We have to go and work individually with Penn, with Jeff, with Einstein, you name it, every specialty, groups of specialists.

We have a very competitive provider system in Philadelphia.

MAJORITY CHAIRMAN MUSTIO: With all due respect, I heard them say that they're paying Lehigh Valley. They have taken that model and they have expanded that to their other 60 counties, is what I heard, with all due respect.

MS. KOCKLER: Yes. But I think you can do that a little better when you are integrated and large and you can

move that girth with you.

MAJORITY CHAIRMAN MUSTIO: Well, I guess all I'm saying is the girth has the data, and I'm just respectfully saying as a Member who, you know, we get inundated with each side, and to me, maybe other Members don't agree, but to me, that was a pretty obvious case study. And if there are some things about that case study that don't work in your system, then that's okay.

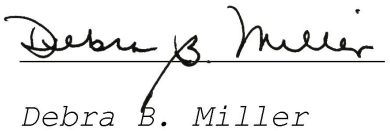
But the data is out there, and with that, at this point -- and I really appreciate it. And I sometimes come across a little bit aggressive, but there's a little bit of passion for this. And to correct somebody, it's not my bill. It's Senator Vogel's bill. But it came to this Committee, and I wanted to make sure it got properly vetted, because as I said in my opening remarks, there were some things that just didn't pass the smell test for me.

But I want to make sure that this does pass the smell test -- for both. I'm not interested in, I'm not interested in implementing legislation that truthfully is going to cause more harm than its intended good, okay? That's a fact. And I said that in the opening remarks, with this bill should not be doing.

Thank you very much.

(At 1:45 p.m., the public hearing adjourned.)

I hereby certify that the foregoing proceedings are a true and accurate transcription produced from audio on the said proceedings and that this is a correct transcript of the same.



Debra B. Miller

Transcriptionist

dbmreporting@msn.com