Statement of The Hospital and Healthsystem Association of Pennsylvania

For the

House Professional Licensure Committee

Submitted by

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Good morning, Chairman Mustio, Chairman Readshaw, and members of the committee. On behalf of The Hospital and Healthsystem Association of Pennsylvania (HAP), Jefferson Health, and Pennsylvania's hospital community, 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 your efforts to improve the quality of life for the citizens of the Commonwealth of Pennsylvania.

I may be a somewhat unique person at this hearing as I both run a telemedicine program (JeffConnect) and am a practicing emergency physician who sees patients in the emergency department (ED), urgent care centers, and via telemedicine.

I believe that every person in this room is familiar with the Triple Aim. We all share the challenge of simultaneously reducing the per-capita costs of health care, improving the patient experience (quality and satisfaction), and improving the health of populations. Telemedicine is one way to accomplish these goals.

Specifically, Senate Bill 780 would:
- Define telemedicine
- Protect patients by outlining who can provide health care services through telemedicine
- Require health insurers to provide reimbursement for telemedicine services if they pay for the same service in person
- Bring consistency to the reimbursement process

Within the next few minutes I will clarify that:

1. Telemedicine is one type of care delivery mechanism that can be utilized for some patients, some of the time, to provide high-quality care
2. Telemedicine positively impacts access, cost, experience, and effectiveness of care
3. Despite complaints about the cost of care, patients in the commonwealth are being deprived of a lower cost care option
4. There already are many protections in place to ensure appropriate care is provided through telemedicine
5. Care rendered through telemedicine technology should not be held to a higher standard than care rendered through other modalities simply because of the use of technology

Overview of Telemedicine

Telemedicine is not a new type of medicine. It is simply a care delivery mechanism. It is one possible modality or mechanism for delivering care; not a different form of care.

Simply put, telemedicine, also called 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 telecommunications technology can be used to deliver high-quality health care.

Telemedicine helps to provide better access to quality, convenient health care, while also keeping costs down and improving health outcomes and population health. It allows patients to access physicians and specialists located across the state while those patients remain in their own communities, surrounded by their own support systems. Telemedicine solves access problems in rural and urban areas. There are specialist shortages in rural areas, but there are appointment shortages in urban areas, making access problematic regardless of geography.

One timely example is telemedicine's ability to amplify the reach of providers capable of intervening in the opioid crisis, as suggested in the Federal Opioid Crisis Response Act of 2018.

Telemedicine also can help:

- Eliminate long waits for in-person appointments
- Save lives when seconds matter
- Help address school safety through in-school behavioral health

Benefits of Telemedicine

The scientific evidence regarding the benefits of telemedicine are beyond question. *Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews,* a comprehensive analysis of 58 systematic reviews on telemedicine outcomes commissioned by the federal Agency for Healthcare Research and Quality (AHRQ), examined the impact of telemedicine on clinical outcomes, utilization, and cost.

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

- Remote patient monitoring
- Managing patients with chronic conditions
- Psychotherapy

Further, the report finds measurable improvements in such measures as:

- Mortality rates
- Quality of life
- Reductions in hospital admissions[i]

The studies considered in the analysis also show that the outcomes of care provided via telemedicine are at least as good as, and sometimes even better than, the outcomes of care delivered "in person." In addition:

- One study found "no significant differences in clinical outcomes or length of stay" between patients receiving in-person versus telemedicine neurological care services.[ii]
- Compared with traditional in-person care, a randomized trial of patients with chronic heart failure found that telemonitoring "improved drug titration and psychological status and reduced hospitalizations."[iii]
- Another randomized trial concluded that "store-and-forward" mobile phone pictures of chest X-rays were not inferior to plain film chest X-rays."[iv] Similarly, two randomized teledermatology trials found store-and-forward technology to yield equivalent improvements in clinical outcomes as in-person care.[v]
- Several studies found that telemental health services were particularly effective relative to in-person care.[vi]
- Implementation of a tele-ICU intervention was associated with reduced mortality and reduced hospital length of stay, improvements in best practice adherence, and lower rates of preventable complications.[vii] A peer-reviewed study of Lehigh Valley Health Network's Advanced ICU showed a significantly lower mortality rate and a lower rate of the use of mechanical ventilation.[viii]

Other research shows that effectiveness has been demonstrated using telemedicine within Pennsylvania for both high- and low-acuity conditions:

- More stroke patients receive treatment with fibrinolytic or clot-busting drugs and more patients have improved functional outcomes, while simultaneously allowing more patients to remain in their community
- Patients cared for by telemedicine are as likely to receive appropriate antibiotic treatment for sinusitis as those cared for in EDs or urgent care centers
    - Halpren-Ruder D, Chang AM, Hollander J, Shah A. Quality assurance in telehealth: adherence to evidence based indicators. Telemed & e-health 2018;e-pub. DOI: 10.1089/tmj.2018.0149)
- Within Pennsylvania, studies have demonstrated benefits within primary care, behavioral health, otolaryngology, urology, pre-admission testing, and care transitions out of the emergency department
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Telemedicine Is an Essential Part of Health Care Transformation

Hospitals and health systems, and health care in general, have transformed, are transforming, and will continue to transform. Thanks to the constant evolution of technology, telemedicine has transformed the landscape of how we can care for patients.

As providers, we are 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 use all tools made available to us in order to improve health; telemedicine is one of those life-saving and life-improving tools. One day, telemedicine may simply be medicine, just as "tele-banking" is just banking.

Telemedicine Measures for Assuring Quality

Following the work completed by the AHRQ, the U.S. Department of Health and Human Services called upon the National Quality Forum (NQF) to convene a multi-stakeholder Telehealth Committee to recommend various methods to measure the use of telemedicine as a means of providing care.

The committee was charged with developing a measurement framework that identifies measures, measure concepts, and serves as a conceptual foundation for new measures where needed to assess the quality of care provided using telemedicine modalities. NQF reviewed more than 390 papers and identified 180 high-quality papers to inform the final report.

The committee reached consensus that a four-domain model provided the best combination of utility, simplicity, and accuracy in identifying and covering the main components of telemedicine, as shown on the next page.

Domains and Subdomains of the Telemedicine Measurement Framework

Domain	Subdomain(s)
Access to Care	• Access for patient, family, and/or caregiver • Access for care team • Access to information
Financial Impact/Cost	• Financial impact to patient, family, and/or caregiver • Financial impact to care team • Financial impact to health system or payor • Financial impact to society
Experience	• Patient, family, and/or caregiver experience • Care team member experience • Community experience
Effectiveness	• System effectiveness • Clinical effectiveness • Operational effectiveness • Technical effectiveness

The central organizing 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, effective manner. The use of telemedicine does not represent a different type of health care, but rather a different method of health care delivery that provides services that are either similar in both scope and outcome or supplemental to those provided during an in-person encounter.

The committee identified six key measure concepts that aligned to each of the domains and subdomains:

1. Travel
2. Timeliness of Care
3. Actionable Information
4. Added Value of Telemedicine to Provide Evidence-Based Best Practices
5. Patient Empowerment
6. Care Coordination

As a physician, I am receiving and gathering sufficient information needed to make decisions about care. This "actionable information" warrants specific attention as it recognizes that providers might not always be able to make a diagnosis within a single visit, whether caring for a patient in person or via telemedicine. After a complete evaluation in the ED, the patient may

need laboratory testing, imaging, or a consult. The same is true in the outpatient office setting. The same is true in telemedicine. The most important thing is that the provider recognizes whether they have sufficient information to determine the right next step (i.e., actionable information). The most appropriate comparison is the care the patient would have received given their other alternatives—it is not simply an in-person visit. For some patients, the alternative is no care at all, maybe due to lack of access or avoidance of care because of a high deductible plan. Some patients may not be able to be treated by telemedicine—they may require in-person care in an emergency department or urgent care center; others require it a primary care office. The standard of care *should* be defined by the medical issue, the provider, and whether or not appropriate care was delivered; *not* by whether it was done "in-person." Telemedicine provides different, sometimes enhanced information. For example, telemedicine offers the provider the advantage of seeing the patients home and might be able to identify the root cause of an asthma exacerbation (animal hair or dust), facilitating better treatment.

Telemedicine Delivers High-quality Care, While Reducing Utilization and Costs

Studies show that, not only can we meet the needs of our patients with telemedicine, but we can do so in a cost-effective way. For example:

- An examination of telemedicine implementation in Pennsylvania found a 5.1 percent decrease in annual costly ER visits[ix].
- Research conducted by Towers Watson indicates that widespread telemedicine adoption could save the health care industry as much as $6 billion annually by reducing readmissions, improving staff utilization, and preventing hospitalizations.[x]
- According to a November 2017 *Issue Brief* published by America's Health Insurance Plans (AHIP), telemedicine can help avoid unnecessary hospitalizations, saving on estimated $6 billion or more annually.[xi]

Telemedicine may decrease the need for costly future events (e.g., ED visit or inpatient admission), reducing downstream costs in both urban and rural settings, despite potentially raising costs in the short-term.[xii] For example:

- Researchers attributed to telemedicine an average of $3,823 in savings for each avoided ED transfer and $5,563 in avoided transportation and indirect patient costs in rural areas. When accounting for start-up technology costs and other factors, the potential net savings posed by tele-emergency care per avoided rural ED transfer totaled $3,923.[xiii]
- Another study found that having a telemedicine-enabled ED can reduce ambulance transports to urban EDs by 56 percent, creating efficiencies among paramedics—who can treat their next patients 44 minutes faster.[xiv]

A fiscal analysis by Maryland General Assembly's Department of Legislative Services noted that "initial studies indicate that telemedicine has the potential to reduce overall costs to health and health-related systems due to better management of chronic diseases, reduced inpatient hospitalization, and lower transportation costs, particularly through the management of chronic diseases."[xv]

Another analysis estimated savings from telemedicine versus in-person visits at $126 per commercial telemedicine visit and $45 per Medicare visit. Additional economic modeling indicates that, for example, a patient covered by commercial insurance would save $66 per visit by using telemedicine services instead of using an urgent care clinic.[xvi]

In our JeffConnect on-demand (direct-to-consumer) telemedicine program:

- 83 percent of patients would have sought care elsewhere; 45 percent of these would have turned to higher-cost EDs or urgent care centers
- Patient satisfaction, as assessed by net promoter score, is 70–90 each month
- Cost saving to the patient or payor is $19–$121 per episode of care, taking into account alternative care sites and post-visit care

In addition, increased access to telemedicine does not increase costs or cause a spike in utilization. Analyses conducted by legislative staff in Vermont and Maryland found that any projected health care utilization increases resulting from enhanced access to services via telemedicine would be offset by cost savings:

- Maryland, in particular, documented that the estimated 2 percent increase in services would ultimately result in avoided transportation and ED admissions, yielding a net savings of $2.5 million annually
- Likewise, similar studies in Colorado, Kentucky, and Texas found "little to no fiscal impact"[xvii]
- Within Pennsylvania, in the JeffConnect program, the minimal increased cost from increased utilization (17%) is more than offset from reduction in ED and urgent care utilization.
    - Nord G, Rising KL, Band RA, Carr BG, Hollander JE. On demand synchronous audio video telemedicine visits are cost effective. Am J Emerg Med. 2018

Reimbursement for Telemedicine

An important component of Senate Bill 780 is the required insurer reimbursement of care delivered through telemedicine if that same health care service is reimbursed when delivered in person. Thirty-eight states and the District of Columbia have laws related to payment for health care delivery via telemedicine and 49 states and the District of Columbia have some form of Medicaid reimbursement for telemedicine in their public program.

The Centers for Medicare & Medicaid Services (CMS) has sent a clear message that it doesn't think the status quo is good enough. In the recently proposed physician fee schedule, CMS acknowledges that the statue 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 of their interface with health care providers. As a result, CMS is proposing to create new services, including "Brief Communication Technology-based Service," "Remote Evaluation of Pre-recorded Patient Information," and "Interprofessional Internet Consultation" that won't be dictated by existing statute. If the Medicare program can be more creative about meeting the needs of our patients, we should expect the same of our private sector partners.

To be clear, some telemedicine is being reimbursed by some insurers. Hospitals and health systems contract with a multitude of payors who then also have a multitude of plans. Although insurers often claim they offer telemedicine services, few offer patients the opportunity to receive appropriate health care from most of their own physicians via telemedicine. Insurers may offer only primary care via a national provider network where patients may not be able to see their own physician. Or, insurers may offer only behavioral health, but they may not offer the patient the opportunity to receive the care from the provider they already see.

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

With Senate Bill 780, Appropriate Protections Are in Place

There are some unfounded concerns about telemedicine. It is not a new type of care. It is just a new care delivery mechanism. There already are many protections in place to ensure appropriate care is provided through telemedicine.

Providers are governed by state licensing boards and follow a medical code of ethics. Strong insurance fraud laws in place also provide important protections. Additionally, Senate Bill 780 does not change an insurer's ability and current practice of reviewing claims for quality indicators, conducting chart reviews, and identifying fraudulent activity or applying penalties already in place.

Pennsylvania's Crimes Code (18 P.S. §4117) or the Insurance Fraud law makes it a crime for providers to commit fraud. Providers are subject to civil penalties and criminal prosecution. The statute states a provider has committed insurance fraud when they "knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim."

In addition, Senate Bill 780 provides for the development of regulations by Pennsylvania's professional licensure boards. Section 3(b) of the bill directs these boards to set the regulations around the type of telemedicine technology and requires that it be safe and secure according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The licensure boards are not to consider or develop regulations around standards of care.

In Conclusion

Despite the fact that no other developed country spends what the United States spends on health care, access to care remains an issue. Pennsylvania's hospitals believe that 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 would like to repeat the five points I made in my opening:

1. Telemedicine is one type of care delivery mechanism that can be utilized for some patients, some of the time, to provide high-quality care
2. Telemedicine positively impacts access, cost, experience, and effectiveness of care
3. Despite complaints about the cost of care, patients in the commonwealth are being deprived of a lower cost care option
4. There already are many protections in place to ensure appropriate care is provided through telemedicine
5. Care rendered through telemedicine technology should not be held to a higher standard than care rendered through other modalities simply because of the use of technology

Our obligation is to provide quality care. I think we all can agree that it does not matter whether that care is provided on the third or fifth floor of a medical complex, is documented in Cerner or Epic platforms, is performed by a physician who is wearing contact lenses or glasses, or whether the patient lives nearby or far away. Similarly, it should not matter whether the care that was provided was rendered via telemedicine or in person. Quality care is quality care.

Thank you for your time today. I am happy to answer any questions you might have.

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