Navigating Telehealth’s Legal and Policy Challenges

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National Telehealth Conference

March 19-20, 2015
1) Introductions

2) Remarks from Chuck Doarn

3) Remarks from Reem Aly

4) Breakout discussions
   - Break into small groups
   - Review prompted questions
   - Report out to the larger group

5) Discussion

6) Conclusion / Next Steps
Background
Charles R. Doarn, MBA, FATA
Education –
  BS – The Ohio State University, 1980
  MBA – The University of Dayton, 1988

Faculty –
  Research Professor of Family and Community Medicine, University of Cincinnati*
  (*Appointments in Environmental Health and Political Science)
  (Faculty appointments at George Washington University, Wright State University, Yale University, Virginia Commonwealth University – Medical College of Virginia, International Space University)

Other Activities –
  Co-Chair – Federal Telemedicine ‘FedTel’ working group
  Co-Chair – Governance Committee – NATO, Romania/Russia Multinational Telemedicine System for Emergencies
  Fulbright Specialist - US Department of State’s Bureau of Education and Cultural Affairs (BECA) and Council for International Exchange of Scholars - Macedonia
  Special Assistant to the Chief Health and Medical Officer, NASA Headquarters, Washington, DC (NASA – Funded)
  Editor – Space Medicine Pioneers: In Their Own Words (NLM-Funded)
  Editor-in-Chief, Telemedicine and e-Health Journal
  Medical Technology Editor – World Health and Medical Policy Journal
  Editorial Board / Reviewer for numerous international journals
  Travel to conduct research, teach or implement healthcare systems (telemedicine) in numerous countries

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The adoption and integration of telehealth into clinical practice presents a number of opportunities as well as challenges. Legal and policy barriers at the state and federal level may limit the use of telehealth tools and methodologies, reducing the potential benefits of telehealth for both patients and clinical practices.

States along with the federal government have codified and adopted policies that impact how telehealth can be incorporated into healthcare. The legal and regulatory environment surrounding telehealth varies greatly across states and at the federal level, creating a policy landscape that can be difficult to navigate.

This session is focused on legal and policy issues surrounding telehealth at the State of Ohio level and at the federal level. During the session, experts in this arena will share information through lecture material, small breakout workgroup activity, and robust dialogue and discussion.

This session will enable the health practitioner to be better informed and equipped to navigate the telehealth legal and policy landscape and implement effective and efficient telehealth tools and services within their organization.
Learning Objectives

Outcomes

- Participants will gain an understanding and an appreciation for the various legal issues surrounding telehealth at the state and federal level.
- Participants will review existing policy and regulatory challenges and opportunities at the state and federal level.
- Participants will learn about what is happening with recent telehealth legislation and policy activity at the state level.
- Participants will learn about what is happening in Washington and how it relates to their clinical practice.
- Participants will share their perspectives on what can be done to promote high quality, cost-effective, and integrated telehealth through state and federal policy.
FedTel - National definition – elusive

- Depends on who is asking, who you ask and who is writing legislation!!
- Institute of Medicine (IOM) – “telemedicine is the use of electronic information and communications technologies to provide and support healthcare when distance separates the participants.”
- American Telemedicine Association (ATA) – “Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status. Closely associated with telemedicine is the term "telehealth," which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services. Videoconferencing, transmission of still images, e-health including patient portals, remote monitoring of vital signs, continuing medical education and nursing call centers are all considered part of telemedicine and telehealth.”

Previous efforts

- WH Information Infrastructure Task Force (VP A. Gore)
- HIAWG (1994)
- OAT Established
- Federally-sponsored meetings
  - OAT (MSU 2008)
- Report(s) to Congress (1997)
- Health IT / Office of the National Coordinator
Is there a single definition for the U.S. Government? Is there a single definition anywhere?

1. All FedTel members surveyed for their definitions
2. Responses collated and reviewed
3. Common nomenclature may be beneficial
4. Current definitions reflect legislative intent and organization’s responsibility
   - Unique populations
Methodology

- Invitation to participate in FedTel
- Information on definition(s) requested from all participant agencies/departments (29)
- Input on the following terms
  - Telehealth
  - Telemedicine
  - Telemonitoring
  - Telepresence
  - Store-and-forward
  - mHealth
Conclusion

1. Common ‘Federal’ definition may be elusive
   a. Unique populations
   b. Telehealth is a broader term
   c. Other terms (e-health, telemonitoring, etc)
2. Inclusion of IT and HIT / communications
3. DHHS is ultimately responsible for population health
4. Lessons learned from others
Original Research
Federal Efforts to Define and Advance Telehealth—A Work in Progress

Charles R. Darrow, MBA,1,2 Sheryl Pratt, MPH,3 Jessica Jacobs, MSHA, CPHIMS,2 Yeri Harris, PhD,3 David M. Bess, PhD,2 William Riley, PhD,2 Christopher Lamer, PharmD, MHS,2 and Anthony L. Oliver, MPH, EMT-B4

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2Department of Family and Community Medicine, College of Medicine, University of Cincinnati, Cincinnati, Ohio
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4Aetna, Washington, D.C.
5Division of Healthcare Quality Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, Rockville, Maryland
6Division of Cancer Control and Population Sciences, National Cancer Institute, Bethesda, Maryland
7Indian Health Service, Rockville, Maryland
8Formerly with the U.S. Department of Health and Human Services, Washington, D.C.
The comments herein do not represent a position by Aetna.

Abstract: Background: The integration of telecommunications and information systems in healthcare is not new or novel; indeed, it is the current practice of telehealth and has been an integral part of medicine in remote locations for several decades. The U.S. Government has made a significant investment, measured in hundreds of millions of dollars, and therefore has a strong presence in the integration of telehealth/telemedicine in healthcare. However, the terminologies and definitions in the telehealth/telemedicine are not always clear and may be confusing to the public, providers, policy makers, and other stakeholders, especially when using these terms. Methodology: The U.S. Government, under the leadership of the Health Resources and Services Administration in the U.S. Department of Health and Human Services, established the Federal Telehealth (FedTel) Working Group, through which all agencies responsible for telehealth/telemedicine are represented by a survey on each agency or department’s definitions and use of terms associated with telehealth. Results and Conclusions: Twenty-five agencies represented by more than 100 individuals participating in the FedTel Working Group identified seven unique definitions of telehealth in current use across the U.S. Government. Although many definitions are similar, there are nuanced differences that reflect each organization’s legislative intent and the population they serve. These definitions affect how telemedicine is being or is being applied across the healthcare landscape, reflecting the U.S. Government’s expansion and influential role in healthcare access and service delivery. The evidence base suggests that a common nomenclature for defining telemedicine may benefit efforts to advance the use of this technology to address the changing nature of healthcare and new demands for services expected as a result of health reform. The key words: telemedicine, telehealth, U.S. Government, healthcare reform.

Background
Telemedicine and telehealth are often used synonymously. While telehealth is a relatively new term, telemedicine has been in use for some time. Although there is disagreement as to the term’s genesis, it is widely agreed that the practice of healthcare through the use of telemedicine was initiated in the 1960s.1 From the start, the U.S. Government’s role in the development and advancement of the use of telemedicine has been significant. In recent decades, several agencies have invested significant funds and ongoing support to advance telemedicine initiatives.2,3

The breadth of the U.S. Government’s investment in advancing the use of telehealth and expanded communications and public awareness to the integration with information technology (IT) to address the clinical efficacy of the use of telemedicine.4

One of the U.S. Government’s key roles is to address market failures to protect the common good.5 As such, the U.S. Government supports services to a diverse set of communities and individuals. Each population base, whether because of its profession or personal circumstances (e.g., astronauts,6 military personnel,7 or disaster victims8) or because of limited access to healthcare services as a result of geography or limited communication (e.g., patients and physicians separated by some distance [e.g. in Massachusetts9 and Nebraska],8 can benefit from telemedicine as a significant and traditional in-person healthcare as well as a tool to be incorporated into current systems of healthcare, education, and communication. Organizations such as the U.S. Department of Agriculture (USDA), the U.S. Department of Health and Human Services (DHHS) specifically the National Library of Medicine (NLM), the National Aeronautics and Space Administration (NASA), the U.S. Army’s Telemedicine and

Telemedicine and e-Health

Evidence Base
41 states have a definition for “telemedicine”
4 states have a statutory definition for “telemedicine” but no reimbursement in Medicaid

17 states have a definition for “telehealth”
Utah – no definition, law is for “digital health services” but references to “telehealth” in provider manual

2 states have no definition or any references
7 states have definition for both
11 states have no statutory reference but Medicaid program reimburses
Approaches

- **Synchronous (real-time)**
  - Video conferencing
  - Virtual whiteboards
  - Chat environments
  - Even the telephone
  - Streaming data (pt A to pt B)

- **Asynchronous (store-and-forward)**
  - Web-based tools
  - File transfers/attachments
  - E-mail
  - Even the fax machine
  - Geographic location is irrelevant since the files are sent and reside on a server until the consulting physician is ready.
Background

- U.S. Government’s investment early on
  - Unique settings (space, battlefield, rural areas, disasters)
  - NASA, NLM, DOD (e.g., TATRC, T2), VA and HHS
Challenges and Opportunities

- Access
- Legal / Licensing
- Reimbursement
- National Trends
- Liability
- Variability by state
- Increased access
- Limited personnel
- Growing demand
- Consumerism
- Healthcare reform
- Informatics
- Willingness to Pay
- Legislation

"It's time we face reality, my friends... We're not exactly rocket scientists."
National Strategies

- Congressional Activities
- FedTel
- Legislation
- Stakeholders
- Affordable Care Act
- Meaningful Use

“They’re the most direct, convenient, and dependable form of communication we have. That’s why the President and I believe mobile phones have so much power to empower the consumer toward a healthcare system in the future…

“The introduction of mobile technology in this move toward electronic health records for all Americans is a huge tool in the tool kit that allow us to drive better care and better outcomes…

“Mobile health has enormous benefits for individuals and improving the health of all Americans…”

HHS Secretary Kathleen Sebelius
October 29, 2009
Federal Involvement

- Office of the National Coordinator
- FedTel and subgroups
- Telehealth, the electronic health record and ACA
- Congressional Direction -
  - Senate Report 113-71 encouraged the Secretary to convene a national working group on e-health and telemedicine.
  - ONC communicated with the Office of the Assistant Secretary for Financial Resources.
Federal Involvement

- Office of the National Coordinator
  - Karen DeSalvo, MD, MPH, MS
- Federal Health IT Strategic Plan 2015 – 2020
  - Adoption of telehealth
Key Federal Issues

- License portability
- Reimbursement
- Interaction with the electronic record
- Fraud and abuse
- Legislation / policy
- CMS and Telehealth
Reimbursement Policies

National view
➢ 44 states reimburse for some live video
➢ 10 states reimburse for remote patient monitoring
➢ Only 7 states have some store & forward reimbursement
➢ 17 states reimburse for transmission/facility fee
Reimbursement Policies

National view
36 States Introduce 100 Telemedicine Related Bills

It’s only February, but telehealth is clearly a priority to state lawmakers. One hundred telemedicine-related bills have been introduced to define telehealth and telemedicine, redefine licensed provider practice standards, remove artificial barriers or improve coverage and payment options. Some bills seek to improve the telemedicine policy landscape while others risk to severely limit health providers’ clinical decision making and patient choice. ATA members are monitoring state activity using the ATA legislative and regulatory trackers, and seizing the opportunity to educate lawmakers about the clinical application of telemedicine and the unintended consequences of over regulation.

Politics of Change

- Each state is different
- Leadership
- Needs
- Strategies
- Legislation
- Ohio’s Role
- Legislation
- Ohio Medicaid Rule 5160-1-18
- Policy landscape challenging to navigate
Reimbursement Policies

- State of Ohio
- HPIO
- Ohio Ranks 40th*
- Shortage of physicians**
- Kettering/Commerce

*www.americashealthrankings.org
**http://hpsafind.hrsa.gov/ -- search Ohio by county
Ohio Medicaid

99201-99215
99241-99245
99251-99255
90791-90792
90804-90858
90863


TO: Eligible Providers of Medicaid Services
Chief Executive Officers, Managed Care Plans (MCPs)

FROM: John B. McCarthy, Director

SUBJECT: Medicaid Coverage of Telemedicine and Related Services

RULE SUMMARY

Rule 5160-1-18, Telemedicine, will be created to establish policy relating to the coverage of Medicaid services delivered through telemedicine.

Changes: Rule 5160-1-18 will be created to establish that, for purposes of Medicaid coverage, telemedicine is the direct delivery of evaluation and management (E&M) or psychiatric services to a Medicaid eligible patient via synchronous, interactive, real-time electronic communication that comprises both audio and video elements. Physicians (MD, DO) and licensed psychologists may be eligible for payment for eligible services rendered through telemedicine, and physician offices, clinics, Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and outpatient hospitals may be eligible for a telemedicine originating payment.

Billing Instructions

Originating Site:

The following provider types will be eligible as an originating site, either using a Q3014 HCPCS code (Q3014) or a GQ modifier: Primary Care Clinic, Outpatient Hospital, Rural Health Clinic (Medical), Federally Qualified Health Clinic (Medical), Physician, Professional Medical Group, Podiatrist, and Optometrist.

When the following codes are billed in lieu of a Q3014, a GQ modifier must be used to signify a telemedicine originating service was also present during the visit:

99201-99215
99241-99245
99251-99255
92002
92004
# Telemedicine in Ohio

<table>
<thead>
<tr>
<th>PHYSICIAN PRACTICE STANDARDS &amp; LICENSURE</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician-patient encounter</td>
<td>B</td>
</tr>
<tr>
<td>Telepresenter</td>
<td>A</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>A</td>
</tr>
<tr>
<td>License &amp; Out-of-State Practice</td>
<td>B</td>
</tr>
</tbody>
</table>

- Allows telemedicine in lieu of an in-person examination.
- Qualifying out-of-state physician has the option of applying for a full license or a telemedicine permit to practice in OH.
- OH Medical Board considering policy revision.

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# State Telemedicine Gaps Analysis

**Physician Practice Standards & Licensure**

- Latoya Thomas
- Gary Capistrant
- September 2014
### Telemedicine in Ohio

<table>
<thead>
<tr>
<th>Parity:</th>
<th></th>
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<tbody>
<tr>
<td>Private Insurance</td>
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</tr>
<tr>
<td>Medicaid</td>
<td>C</td>
</tr>
<tr>
<td>State Employee Health Plan</td>
<td>F</td>
</tr>
</tbody>
</table>

#### Medicaid Service Coverage & Conditions of Payment:

<table>
<thead>
<tr>
<th>Category</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Setting</td>
<td>F</td>
</tr>
<tr>
<td>Eligible Technologies</td>
<td>F</td>
</tr>
<tr>
<td>Distance or Geography Restrictions</td>
<td>A</td>
</tr>
<tr>
<td>Eligible Providers</td>
<td>F</td>
</tr>
<tr>
<td>Physician-provided Services</td>
<td>F</td>
</tr>
<tr>
<td>Mental/Behavioral Health Services</td>
<td>B</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>B</td>
</tr>
<tr>
<td>Home Health</td>
<td>F</td>
</tr>
<tr>
<td>Informed Consent</td>
<td>F</td>
</tr>
<tr>
<td>Telepresenter</td>
<td>A</td>
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</tbody>
</table>

#### Innovative Payment or Service Delivery Models:

<table>
<thead>
<tr>
<th>Model</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>State-wide Network</td>
<td>✓</td>
</tr>
<tr>
<td>Medicaid Managed Care</td>
<td>✓</td>
</tr>
<tr>
<td>Medicare-Medicaid Dual Eligibles</td>
<td>✓</td>
</tr>
<tr>
<td>Health Home</td>
<td>✓</td>
</tr>
<tr>
<td>HCBS Waiver</td>
<td>✓</td>
</tr>
<tr>
<td>Corrections</td>
<td>✓</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

- No telemedicine parity law despite a multi-year effort to introduce legislation regarding coverage under private insurance and Medicaid.\(^{175}\)
- Medicaid
  - Law enacted in 2014 authorizing Medicaid to expand coverage of telemedicine.\(^{176}\) Regulations are pending.\(^{177}\)
- Current coverage includes school-based speech therapy, behavioral health counseling and therapy, mental health assessment, pharmacological management, and community psychiatric supportive treatment service via interactive audio-video only.\(^{178}\)
- Medicaid allows beneficiaries to choose the patient location when telemedicine is used for mental/behavioral health services.
- Requires written informed consent for mental and behavioral health services.

Innovation

- CMS approved health home proposal allows service delivery via in-person, by telephone, or by video conferencing.\(^{179}\)
The Need for License Portability

• Healthcare rapidly changing
  – ACA implementation and need to increase access and contain costs
  – Rapidly developing technologies
  – Integration of health care delivery systems

• In this environment, PORTABILITY of medical licenses is critical and should be facilitated

• Goal: Enhance portability, while ensuring medical quality and patient protection
What is an Interstate Compact?

- A contract between compact states
- Constitutionally authorized
- Responds to a collective problem without ‘nationalization’ of the issue
- Retains state sovereignty on issues traditionally reserved to state jurisdictions
Key Principles

- Participation voluntary for both physicians and state boards of medicine.
- Creates another pathway for licensure, but does not otherwise change a state’s existing *Medical Practice Act*.
- Regulatory authority remains with the participating state medical boards.
- The practice of medicine occurs where the patient is located.
- Compliance with the statutes, rules and regulations of state where patient located.
- State boards aware of physicians practicing in the state.
Clinical Applications

- Congressional hearings
  Spring 2014
- OMB hearings/testimony
- Influencing legislation
- Driving policy
- Impacting research portfolio(s)

Original Research
The Empirical Foundations of Telem medicine Interventions for Chronic Disease Management

Rashid L. Boksh, PhD,1 Gary W. Shannon, PhD,2 and Brian R. Smith, MSc

Contributing Authors: Dale C. Averson, MD,3 Nina Antonacci, PhD, RN,4 William G. Barton, MD,5 Nuara Bokshur, MPH,6 Edward M. Brown, MD,6 Molly J. Clancy, MD,7 Charles R. Deem, MBA,8 Stuart Ferguson, PhD,9 Jim Griffin, PhD,9 Elizabeth A. Kropimski, PhD,10 Joseph C. Kvedar, MD,10 Jonathan Landis, MPA,11 Ronald C. Mermel, MD,12 Thomas Nishita, MD,12 Ronald Popovich, MD,12 Keran S. Rhee, MD,12 Jay H. Sanford, MD,12 Andrew R. Wesson, MD,12 Ronald S. Weinstein, MD,12 and Peter Yellowlees, MD12

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11University of Arizona, Tucson, Arizona.
12Partners Health Care, Harvard University, Cambridge, Massachusetts.
13American Telem medicine Association, Washington, DC.
14University of California Davis, Sacramento, California.
15University of Pittsburgh Medical Center, Pittsburgh, Pennsylvania.
16University of Virginia, Charlottesville, Virginia.
17The Global Telemedicine Group, Mâcon, Virginia.

Abstract
The telemedicine intervention in chronic disease management promises to involve patients in their own care, provides continuous monitoring by their healthcare providers, identifies early symptoms, and responds promptly to exacerbations in their illnesses. This review set out to establish the evidence from the available literature on the impact of telemedicine for the management of chronic diseases: congestive heart failure, stroke, and chronic obstructive pulmonary disease. By design, the review focuses on a limited set of representative chronic diseases because of their current and increasing importance relative to their prevalence, associated morbidity, mortality, and cost. Furthermore, these three diseases are amenable to timely interventions and secondary prevention through telemonitoring. The preponderance of evidence from studies using rigorous research methods poses to beneficial results from telemonitoring in its various manifestations, with a few exceptions. Generally, the benefi ts include reductions in use of service, hospital admissions/re-admissions, length of hospital stays, and emergency department visits typically declined. It is important that there were some reductions in mortality. Few studies reported actual or mixed findings.

Key words: telem medicine, telehealth, telereuscare, evidence, chronic disease, teleboost, telepalnology

Introduction and Overview
This report provides an analysis of the extant scientific evidence concerning the impact of telemedicine on three critical issues in healthcare: access, quality, and cost—with a focus on chronic disease management. We begin with a survey review of these issues in the United States, followed by brief discussion of the history and promise of telemedicine in addressing them. Subsequently, the focus turns to a review of the available evidence from rigorous empirical studies regarding the effects of telemedicine in the management of chronic diseases, specifically, congestive heart failure (CHF), stroke, and chronic obstructive pulmonary disease (COPD). Finally, we turn our attention to the economics of telemedicine.

The reason for our focus on the management of chronic diseases is twofold. (1) The vast number of published research articles dealing with the wide variety of telemedicine applications and the need to reach a conclusion regarding the available evidence render an all-inclusive approach rather impractical. More important is that a voluminous report may not add a commensurate amount of information that would alter the conclusions reached by a focused approach. (2) Chronic disease is highly prevalent, is projected to increase substantially in the foreseeable future, and is costly and potentially manageable via telemedicine.

For convenience and clarity, we use “telemedicine” as an inclusive term throughout this report to refer to the delivery of healthcare via information and communication technology (ICT). As such, it includes “telehealth,” “e-health,” “mobile health” (m-health), and “connected health.”
Cost Effectiveness

It is not just the bottom line!

- Healthcare reform (increase total number of patients)
- Characteristics of cost
  - Travel – distance/geography
  - Opportunity costs (cost of doing / not doing)
  - Time / time lost
  - Security of device (theft, misuse, etc.)
- Cost of new approaches
- Limited data available on cost savings of eHealth
- Trends are indicative of benefit
- Efficiency
Evidence-based Medicine / Guidelines
Evidence Base

- Telemedicine and e-Health Journal
- Journal of Telemedicine and Telecare
- Intl J Telemedicine & Applications
- Annual Rev CyberTherapy & Telemedicine
- Ukranian J Telemedicine & Medical Telematics
- J eHealth Technology & Application
- European J ePractice
- Intl J e-Health & Medical Communication
- J Pervasive & Mobile Computing
- J Healthcare Engineering
- J Health & Technology
- J Technology in Human Service
- Journal of Smart Homecare Technology and TeleHealth
- Others Specialty Journals
  - JAMA
  - Health Affairs
  - BMJ
  - NEJM
Telemedicine is an emerging strategy to address access and quality of care issues. The term telehealth includes subtopics such as an exchange of medical information from one site to another via electronic communications for the purpose of providing clinical support or care; remote clinical care and patient monitoring; e-health; professional and patient-related health education; and health information management.

On September 13, 2012, the State Medical Board of Ohio adopted an interpretive guideline concerning Ohio Administrative Code Rule 4731-11-09 and the requirement to personally physically examine and diagnose a patient prior to initially prescribing. The interpretive guideline applies solely to cases that involve prescribing or personally furnishing non-controlled substances and recognizes that with advances in medical technology it may be possible for the "personal" and "physical" examination, required by Rule 4731-11-09, to occur when the provider and patient are located in remote locations.

On January 29, 2014, the Ohio Senate passed House Bill 123. The bill doesn't attempt to establish standards for payment for telemedicine services, but instead requires Medicaid to establish those standards. The bill neglects to set any payment standards for private insurers relative to telemedicine services choosing to focus on Medicaid payments alone.

On January 2, 2015, Ohio Medicaid telemedicine payment rule OAC 5160-1-18 went into effect and approved billing instructions for the rule were released.
Ohio Academy of Family Physician Resources
• Summary of OAFP Board of Directors Telemedicine Discussion (October 12, 2014)
• Will Technology Make Virtual Primary Care Visits Common? (The Ohio Family Physician, Summer 2012)
• Recent News Articles Prompt Telemedicine Discussions (Weekly Family Medicine Update, April 10, 2012)

Health Policy Institute of Ohio Resources
• Second Annual Telehealth Leadership Summit (August 19, 2014)
• Telehealth Leadership Summit: Key findings and Considerations (August 2013)
• Looking Ahead: Understanding Telehealth in Ohio (April 16, 2013)
• Telehealth Resource Page

Additional Information and Resources
• Telemedicine Kiosk Company Signs Technology Integration Deal with Sprint (MedCity News, February 16, 2012)
• Rite Aid Clinics Place New Twist on ‘Doc in a Box’ (American Medical News, February 6, 2012)
• HealthSpot Hopes Compact Kiosks Can be Next Big Thing in Medicine (Columbus Business First, February 3, 2012)
• Federation of State Medical Boards’ Telemedicine Report (March 10, 2011)
- See more at: http://www.ohioafp.org/advocacy/advocacy-alerts/telemedicine/#sthash.33DZQduU.dpuf
Resources (partial list)

- Centers for Medicare and Medicaid Services

- Office for the Advancement of Telehealth (DHHS, HRSA)
  [http://www.hrsa.gov/ruralhealth/about/telehealth/](http://www.hrsa.gov/ruralhealth/about/telehealth/)
  ✓ Resource Centers

- American Telemedicine Association
  ✓ Standards
  ✓ Industry trends

- Telemedicine and e-Health Journal
  ✓ Evidence base (20 years)

- Health Policy Institute of Ohio
  [www.healthpolicyohio.org/](http://www.healthpolicyohio.org/)

- American Academy of Family Physicians

- Ohio Academy of Family Physicians
• Established in 2006, funded by the Office for the Advancement of Telehealth
• Twelve regional centers
• One national technology assessment center
• One national policy center - CCHP
• Collectively form a network of telehealth program expertise and experience
• Independently serve a designated region

TelehealthResourceCenter.org
Coming Soon ....

www.telehealthpolicy.us

- A one stop shop for accurate and up-to-date information on telehealth policy, legal issues and Health Information Technology
- Includes an interactive “Policy Map” that will reveal telehealth laws, regulation, state Medicaid policy and pending legislation for all 50 states and D.C.

Telehealth technologies are valuable assets to help achieve the “Triple Aim” of improved quality of care, better health outcomes, and lowered costs.

Learn More >>
Exercise

1. Small groups (depends on attendance)
2. Discuss each question provided
3. Spend about 20 minutes on these
4. Brief the entire group
Exercise

- What effects your efforts the most?
- What are some challenges and opportunities?
- What are the goals of the telehealth program you/your organization has implemented or is thinking about implementing (i.e. value proposition)?
- What are the primary policy challenges you/your organization has faced with implementation of a telehealth program and achieving those goals?
- How is your organization addressing these policy challenges?
- What types of policies, if put in place, would facilitate more effective telehealth delivery?