MARYLAND HEALTH CARE COMMISSION

Maryland Telemedicine Task Force

Final Report

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Prepared for
the Governor of the State of Maryland,
the Senate Finance Committee,
and the House Health and Government Operations Committee

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Executive Summary

The Maryland Health Care Commission (MHCC), in conjunction with the Maryland Health Quality and Cost Council, convened the Telemedicine Task Force (Task Force) in July 2013 to study the use of telehealth throughout the State and identify opportunities to expand telehealth.[1, 2] Telehealth holds the promise of being an effective health care delivery alternative for achieving the goals of health care reform, which includes increasing access to care, improving patient outcomes, and supporting the delivery of more comprehensive care. When appropriately used, telehealth has the potential to increase access to care, improve patient outcomes, and generate cost savings.[3, 4, 5]

While telehealth technology adoption is increasing, its use remains low. In calendar year 2013, only 16 practitioners submitted 132 telemedicine service claims to State-regulated payors.[6] Since 2012, Maryland Medicaid established three pilot programs: a telemental health program that began in 2012; a telemedicine program for rural access that began in calendar year 2013; and a telemedicine program for stroke and cardiovascular conditions treated within hospital emergency departments. Maryland Medicaid received no applications for the stroke and cardiovascular program; one hospital applied for and was approved for the rural access program, and submitted only two claims for reimbursement. Under the telemental health pilot, roughly 4,450 telemental health claims were submitted by Federally Qualified Health Centers, mental health clinics, and physicians.[7,8]

This report presents the Task Force recommendations for expanding telehealth adoption in Maryland.[9] The Task Force consisted of three advisory groups: the Clinical Advisory Group (CAG), the Finance and Business Model (F&B) advisory group, and the Technology Solutions and Standards (TSS) advisory group. The CAG recommended ten use cases[10] for implementation in pilot projects to accelerate use of telehealth. These use cases are intended to: have an impact on vulnerable

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[1] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

[2] The 2014 Task Force recommended transitioning from using the term *telemedicine* to the term *telehealth*, which includes related terminology, such as telemedicine, telecare, telelearning, etc. See Appendix B for a glossary of terms. *Telehealth* as defined by the Task Force is: the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner.

[3] Information Technology and Innovation Foundation, *Unlocking the Potential of Physician-to-Patient Telehealth Services,* May 2014. Available at: www2.itif.org/2014-unlocking-potential-physician-patient-telehealth.pdf.

[4] Health Affairs, *Connected Health: A Review of Technologies and Strategies to Improve Patient Care with Telemedicine and Telehealth*, 2014, 33(2).

[5] The Commonwealth Fund, *Scaling Telehealth Programs: Lessons from Early Adopters,* January 2013. Available at: www.commonwealthfund.org/~/media/files/publications/case-study/2013/jan/1654_broderick_telehealth_adoption_synthesis.pdf.

[6] Claims data includes CareFirst BlueCross BlueShield and UnitedHealthcare; CIGNA reported zero claims, and Aetna, Inc. did not respond to requests for information.

[7] The Department of Health and Mental Hygiene Medical Assistance (Medicaid) Program launched two telehealth programs in 2013 - the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program. These new programs expand upon the Telemental Health Program, implemented in 2012. More information is available at: mmcp.dhmh.maryland.gov/sitepages/Telemedicine%20Provider%20Information.aspx. Legislation passed during the 2014 legislative session requires Medicaid to expand its coverage of telehealth services, in certain situations. *Maryland Medical Assistance Program – Telemedicine*, Senate Bill 198 (Chapter 141) (2014 Regular Session). See Appendix C; available at: mgaleg.maryland.gov/2014RS/chapters_noln/Ch_141_sb0198T.pdf.

[8] Information obtained from the Maryland Department of Health and Mental Hygiene in June 2014.

[9] An interim report on the work of the Task Force was released in December 2013. MHCC, *Maryland Telemedicine Task Force Interim Report*, December 2013. Available at: mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TTF_Interim_rpt_20131201.pdf. See Appendix D.

[10] Use cases are defined as a pilot projects narrow in scope to test concepts before introducing them more widely.

populations; be consistent with the goals of health care reform; and be implementable, testable, and cost-effective.[11, 12] The use cases are as follows:

1. *Improve transitions of care between acute and post-acute settings through telehealth*
2. *Use telehealth to manage hospital Prevention Quality Indicators*[13]
3. *Incorporate telehealth in hospital innovative care delivery models through ambulatory practice shared savings programs*
4. *Require value-based reimbursement models to factor in reimbursement for telehealth*
5. *Use telemedicine in hospital emergency departments and during transport of critically ill patients to aid in preparation for receipt of patient*
6. *Incorporate telehealth in public health screening and monitoring with the exchange of electronic health information*
7. *Deploy telehealth in schools for applications including asthma management, diabetes, childhood obesity, behavioral health, and smoking cessation*
8. *Use telehealth for routine and high-risk pregnancies*
9. *Deploy telehealth services widely at community sites, connected to health care professionals and/or the statewide health information exchange*
10. *Use telehealth for remote mentoring, monitoring and proctoring of health care practitioners through telehealth for the expansion, dispersion and maintenance of skills, supervision, and education*

The Task Force developed supporting recommendations for the use cases. The F&B advisory group focused on identifying the finance and business model challenges of implementing the use cases, such as: reimbursement structure; practitioner availability for remote care delivery, monitoring, and care coordination; and practice transformation and redesign. The F&B advisory group recommended that organizations deploying the use cases develop solutions unique to their organization and patient population to mitigate the challenges. Sustainability of the use cases is unlikely absent addressing the financial and business model challenges. The TSS advisory group determined that the use cases could be implemented with current telehealth technology and identified a barrier to telehealth diffusion as the lack of availability of information about telehealth services. The TSS advisory group recommended the development of a telehealth provider directory (telehealth directory) that will be a publicly available online listing of Maryland telehealth providers. The Task Force also recommended transitioning from using the term *telemedicine* to the term *telehealth* because telehealth encompasses a broader scope of health care delivery.[14] The Task Force recommended adopting the following definition for *telehealth*: *the delivery of health*

[11] Some of the telehealth use cases are already in practice today.
[12] The use cases are not intended to imply which health care services should be reimbursed by payors.
[13] Hospital prevention quality indicators are a set of measures used nationally to assess quality and access to care in communities. For more information, visit: qualityindicators.ahrq.gov/modules/pqi_resources.aspx.
[14] Telemedicine, as currently defined in Md. Code Ann., Insurance § 15–139, is: *as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.*

education and services using telecommunications and related technologies in coordination with a health care practitioner.[15, 16]

Funding Request

The Task Force requests the General Assembly provide $2.5 million for the implementation of select telehealth use cases. The MHCC proposes to use its grants-making authority for issuing telehealth use case pilot projects.[17] If funding is appropriated, MHCC will request innovative telehealth pilot project applications. The funding amount per awardee will be determined based on the number and strength of the proposals made in the grant applications. Implementation of the funded pilot projects will be structured as two-year partnerships, in which MHCC and each grantee will work collaboratively to implement and assess the impact of telehealth on quality of care, access to care, and cost of care. Part of the funding will be used to implement the telehealth provider directory. The funding will accelerate telehealth diffusion in the State, further enable the use of telehealth in health care reform, and inform the design of future telehealth uses in Maryland. The $2.5 million in funding from a source identified by the General Assembly would be an increase to the existing MHCC budget. Funding for implementation of the telehealth use cases is not included in the annual MHCC budget. When grant funds are depleted, a funding source to maintain the telehealth directory will need to be identified.

Introduction

In 2013, the General Assembly enacted legislation requiring the Maryland Health Care Commission (MHCC), in conjunction with the Maryland Health Quality and Cost Council (Council), to study the use of telehealth[18] by reconvening the Telemedicine Task Force (Task Force).[19] The law directed the Task Force to: identify opportunities for using telehealth to improve health status and care delivery in the State; assess factors related to telehealth, identify strategies for telehealth deployment in rural areas; and determine the ability of telehealth to meet any increased demand for health care services due to implementation of the Patient Protection and Affordable Care Act (PPACA).[20] The PPACA provides a framework for transforming the health care delivery system for better quality health care that is more cost-effective.[21] Emphasis on achieving health care reform,

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[15] Telehealth includes the following technologies: real-time audio video conferencing; store-and-forward; remote monitoring; and mobile health.
[16] DHMH may specify by regulation the types of health care providers eligible to receive reimbursement for services delivered to Maryland Medicaid patients through telemedicine. DHMH may also authorize coverage and reimbursement for health care services delivered through store-and-forward technology or remote patient monitoring subject to the limitations of the State budget and in accordance with Medicaid regulations.
[17] Md. Code Ann., Health-Gen. §19-109 (2014).
[18] In this report, the term *telemedicine* is included in the term *telehealth*; the term *telemedicine* is used where it exists in law. The 2014 Task Force recommended transitioning from using the term *telemedicine* to the term *telehealth*, which includes related terminology, such as telemedicine, telecare, telelearning, etc. See Appendix B for a glossary of terms.
[19] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.
[20] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.
[21] Centers for Medicare & Medicaid Services, *CMS Strategy: The Road Forward 2013-1017*. Available at: www.cms.gov/About-CMS/Agency-Information/CMS-Strategy/Downloads/CMS-Strategy.pdf.

coupled with evolving technologies, has resulted in greater interest in expanding the adoption of telehealth.[22, 23]

If used appropriately within certain contexts, telehealth has the potential to enhance access to health care and improve a patient's health status.[24] Transforming the health care delivery system requires an industry-wide fundamental change from the existing volume-based fee-for-service care delivery and payment model toward value-based delivery and payment models. National health care reform efforts are sparking innovation in how health care is delivered and compensated. Telehealth, integrated with other health information technologies, such as electronic health records (EHRs) and health information exchanges (HIEs), can help provide the infrastructure needed to achieve the goals of health care reform.

Limitations

Recommendations presented in this report are based on the work of the Task Force and reflect the general consensus reached by the participants; minority opinions are not included. The telehealth use cases identified by the Task Force are not an exhaustive list of all possible telehealth applications. The Task Force did not evaluate existing telemedicine reimbursement policies of State-regulated payor (payor) the Maryland Medical Assistance Program. The Task Force did not evaluate the financial impact of the recommendations on payors and providers. This report does not assess telehealth licensure requirements for non-physician practitioners.

Background

Telehealth vs. Telemedicine

The terms *telehealth* and *telemedicine* are often used interchangeably, and terminology and definitions in the industry vary.[25] To harmonize the wide range of definitions that exist locally and nationally, in this report the term *telehealth* encompasses *telemedicine. Telemedicine* is used in this report where it exists in law.

The existing definition of *telemedicine* in Maryland law and is limited to real-time audio video conferencing.[26] The term *telehealth* expands this definition to include the use of communication and information technologies not only for delivering health care services remotely, but also for

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[22] National Academy of Sciences, *The Role of Telehealth in an Evolving Health Care Environment: workshop summary*, 2012.
[23] Health Affairs, *Telehealth Among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption*, 2014, 33(2).
[24] The Information Technology and Innovation Foundation, *Unlocking the Potential of Physician-to-Patient Telehealth Services,* May 2014. Available at: www2.itif.org/2014-unlocking-potential-physician-patient-telehealth.pdf.
[25] Journal of Telemedicine and e-Health, *Federal Efforts to Define and Advance Telehealth—A Work in Progress,* May 2014. See Appendix E for information about how telehealth is defined across Federal agencies.
[26] The existing definition, found at Md. Code Ann., Insurance §15-139(a)(1), provides that telemedicine means: *as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located*. Under Md. Code Ann., Insurance §15-139(a)(2), telemedicine does not include: (i) an audio-only telephone conversation between a health care provider and a patient; (ii) an electronic mail message between a health care provider and a patient; or (iii) a facsimile transmission between a health care provider and a patient.

public health, education, and care coordination.[27] The term *telehealth* is intended to include both non-medical therapeutic services (e.g., mental health counseling) and non-clinical services (e.g. occupational therapy).

Telehealth is defined as: *the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner* and includes the following technologies:[28, 29, 30]

- Real-time audio video conferencing: virtually connects patients with practitioners (sometimes referred to as virtual visits) and may serve as an alternative to an in-person visit;
- Store-and-forward: uses non-real-time communication, including email or other electronic transmission, to send clinical information, such as an x-ray, to health care practitioners for clinical review at a convenient time offline;
- Remote monitoring: collects and transmits data on specific health indicators, such as blood pressure or heart rate, to health care practitioners for tracking purposes; and
- Mobile health (mHealth): uses mobile communications devices, such as smartphones, for health services and information.

Health Information Technology

Telehealth is considered to be a key element of health information technology (health IT). Effective health IT also includes the adoption and use of EHRs and HIE. Widespread adoption and effective use of health IT is generally considered essential to support health care reform.[31, 32, 33, 34, 35, 36] The use of these technologies in health care delivery requires the development of privacy and security policies to protect electronic health information. Expansion of health IT in Maryland is one of the Governor's priorities. Over the last six years, the General Assembly adopted legislation that advanced health IT in Maryland, including the following:[37]

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[27] Although this report broadens the definition of *telemedicine*, the Task Force recognizes that Medicaid cannot reimburse for all services included in the definition.
[28] Information Technology and Innovation Foundation, *Unlocking the Potential of Physician-to-Patient Telehealth Services,* May 2014. Available at: www2.itif.org/2014-unlocking-potential-physician-patient-telehealth.pdf.
[29] Journal of Telemedicine and e-Health, *Federal Efforts to Define and Advance Telehealth—A Work in Progress,* May 2014.
[30] Maryland Medicaid does not currently reimburse for activities that do not include a patient as part of the encounter, thus store-and-forward, remote monitoring, and mHealth would not be eligible.
[31] Institute of Medicine, *Health IT and Patient Safety: Building Safer Systems for Better Care,* 2012. Washington, DC: The National Academies Press.
[32] Annals of Internal Medicine, *Health Information Technology: An Updated Systematic Review With a Focus on Meaningful Use*, January 2014. Available at: annals.org/article.aspx?articleid=1811028.
[33] Rand Corporation, *Redirecting Innovation in U.S. Health Care*, 2014. Available at: www.rand.org/content/dam/rand/pubs/research_reports/RR300/RR308/RAND_RR308.pdf.
[34] Agency for Healthcare Research and Quality (AHRQ), *Electronic Health Records*, September 2013. Available at: healthit.ahrq.gov/ahrq-funded-projects/emerging-lessons/electronic-health-records.
[35] Journal of Telemedicine and e-Health, *Critical Steps to Scaling Telehealth for National Reform*, November 2008: 990-994.
[36] Journal of Telemedicine and e-Health, *National Telemedicine Initiatives: Essential to Healthcare Reform*, July/August 2009: 600-610.
[37] Legislation and regulations specific to telemedicine are referenced in the *Telehealth Legislation* section of this report.

- Md. Code Ann., Health-General § 19-143 provided the basis for the increased adoption of health IT[38]
    - Required payors to offer incentives to practitioners who use certified EHRs
        - COMAR 10.25.16, *Electronic Health Record Incentives*, adopted by MHCC in October 2011, implements the law by requiring certain payors to provide EHR adoption incentives to primary care practices
        - As of 2013, roughly 57 percent of office-based physicians in Maryland have adopted an EHR, an increase from about 28 percent in 2010,[39] compared to roughly 48 percent nationally[40]
    - Required MHCC to designate a statewide HIE
        - In 2009, the MHCC designed the Cheseapeake Regional Informaiton System for our Patients (CRISP) as the statewide HIE
        - This designation enabled the development of an entity to facilitate electronic exchange of patient health information in the State, helping hospitals and practitioners to access available patient health information and coordinate patient care
    - Required MHCC to designate one or more management service organizations (MSOs)
        - COMAR 10.25.15, *Management Service Organization State Designation* was adopted by MHCC in November 2010
        - MSOs provide services that support practitioners in improving the patient experience of care, improving the health of the population, and reducing health care costs; as of 2014, there are roughly 10 State-Designated MSOs
- Md. Code Ann., Health-General §19-1A-01, *et seq*. required MHCC to establish the Maryland Multi-Payor Patient Centered Medical Home (PCMH) Program (MMPP) in 2011, which incorporated health IT as a key component for primary care practice transformation[41]
    - Required MHCC to develop a three-year pilot, which aims to improve the health and satisfaction of patients and slow the growth of health care costs in Maryland, while supporting the satisfaction and financial viability of primary care practitioners in the State
    - Approximately 52 primary care practices were selected for participation in the MMPP pilot; a study is underway to determine the three-year results of the pilot
- Md. Code Ann., Health-Gen. §§4-301 and 4-302 were adopted by the General Assembly to protect electronic patient information[42]
    - Required MHCC to adopt regulations for the privacy and security of protected health information exchanged through an HIE; the regulations:

[38] Md. Health-General §§1-101, 15-101, 15-105.2, 19-101, 19-142 - 143, 19-706. See Appendix F.
[39] 2013 Maryland Board of Phsyician Licensure Data, a database of physician responses to the bi-annual licensure survey.
[40] National Center for Health Statistics, *Use and Characteristics of Electronic Health Record Systems Among Office-Based Physician Practices: United States, 2001 – 2013*, January 2014. Available at: www.cdc.gov/nchs/data/databriefs/db143.pdf.
[41] Md. Health-General §19-1A-01, *et seq*. Chapters 5 and 6, Acts 2010. See Appendix G.
[42] Md. Code Ann., Health-Gen. §§4-301 and 4-302 (2011).

- Protect the rights of health care consumers concerning information accessed, used, or disclosed through an HIE
- Govern access, use, and disclosure of sensistive health information
- Establish auditing requirments
- Require notice of breach

Telehealth Landscape

Telehealth Technology Adoption

The American Telemedicine Association (ATA) reports that more than 200 telehealth networks are operating nationally and roughly 3,000 telehealth service sites exist.[43] To date, telehealth technology adoption has occurred mostly within hospital systems and among practitioners providing consultative services to other practitioners.[44] About 42 percent of hospitals nationally have telehealth capabilities.[45] Recent advances in technology and rising consumer adoption of real-time audio video communications have made practitioner-to-patient and practitioner-to-practitioner telehealth services more practical.[46] The number of patient virtual visits in 2014 is estimated to be about 75 million; increases in patient virtual visits are generally attributed to faster Internet speeds, more familiarity with technology, greater use of computers, and prevalent adoption of mobile devices.[47]

Telehealth adoption in Maryland has increased slowly in recent years; however, the use of telehealth remains disappointingly low. While approximately 61 percent of general acute care hospitals in Maryland reported using telehealth, on average fewer than five percent of hospital departments reported using telehealth.[48] Teleradiology, remote monitoring, and image review were the most common telehealth services rendered by hospitals.[49] Telehealth adoption among physicians in Maryland is low, at about nine percent in 2013.[50, 51] Maryland physicians using telehealth reported mostly using it for diagnosis and patient monitoring.[52]

Telehealth Reimbursement

Even though the technology and a payment structure to support telehealth are largely in place today, practitioner requests for reimbursement for telehealth services are minimal. Beginning in October 2012, Maryland law required private payor reimbursement for certain telemedicine

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[43] ATA, *What is Telemedicine?* Available at: www.americantelemed.org/about-telemedicine/what-is-telemedicine#.U77C9fldWCQ.
[44] CHMB, *Top 6 Telehealth Trends for 2013*, April 2013. Available at: www.chmbinc.com/top-6-telehealth-trends-for-2013/.
[45] Health Affairs*, Telehealth among US Hospitals: Several Factors, Including State Reimbursement and Licensure Policies, Influence Adoption,* February 2014.
[46] CHMB, *Top 6 Telehealth Trends for 2013*, April 2013. Available at: www.chmbinc.com/top-6-telehealth-trends-for-2013/.
[47] These figures include the U.S. and Canada. Deloitte, *eVisits: the 21st Century Housecall*, August 2014. Available at: www2.deloitte.com/content/dam/Deloitte/global/Documents/Technology-Media-Telecommunications/gx-tmt-2014prediction-evisits.pdf.
[48] MHCC, *Health Information Technology: The Sixth Annual Assessment of Maryland Hospitals*, September 2014. See Appendix H for the types of telehealth services provided by hospitals and the types of technology used.
[49] MHCC, *Health Information Technology: The Sixth Annual Assessment of Maryland Hospitals*, September 2014. See Appendix H for the types of telehealth services provided by hospitals and the types of technology used.
[50] 2013 MBP Physician Licensure file, a database of physician responses to the bi-annual licensure survey.
[51] National comparison data are not available.
[52] 2013 MBP Physician Licensure file, a database of physician responses to the bi-annual licensure survey.

services.[53] During the nine months following the effective date of the law, only about 50 health care practitioners submitted roughly 78 telehealth claims to payors. In 2013, about 16 practitioners were reimbursed by payors for services rendered via telehealth for roughly 132 claims.[54] When submitting data to MHCC, payors indicated that practitioners may be rendering services through telehealth but not using the appropriate modifier in claims submission, therefore underestimating real telehealth utilization. The Task Force did not evaluate payors' awareness initiatives to inform practitioners about the availability of telehealth reimbursement.

Government payors have historically restricted coverage of telehealth services, generally due to budget limitations or concerns about what constitutes the appropriate use of telehealth.[55, 56, 57] As clinical evidence on effectiveness of targeted telehealth services for specific populations has grown, reimbursement for telehealth services among government payors is increasing, although only at a modest pace.[58, 59] Medicare telehealth reimbursement in 2014 covers approximately 73 telehealth services, as compared to about 60 telehealth services in 2013.[60, 61, 62] Medicare reimbursement for telehealth services is restricted to rural areas, which may continue to hinder adoption since in Maryland, less than five percent of census tracts are designated as rural.[63] However, using telehealth to increase rural patient access to specialty services has been shown to be cost effective

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[53] Md. Code Ann., Insurance § 15–139. See Appendix I.

[54] CareFirst BlueCross Blue Shield and UnitedHelathcare reported these claims; Cigna Health Care Mid-Atlantic Region reported they received no claims and Aetna, Inc. was unresponsive to requests for information.

[55] The Maryland Department of Health and Mental Hygiene's (DHMH) Medical Assistance (Medicaid) Program launched two telehealth programs - the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program. The new programs expand upon the Telemental Health Program, implemented in 2012. More information is available at: mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx. Legislation passed during the 2014 legislative session requires Medicaid to expand its coverage of telehealth services, in certain situations.

[56] University of Maryland School of Medicine, *Report on Policies Regarding Use and Reimbursement for Telemedicine Services in Maryland and Other States,* 2006. Available at: dhmh.maryland.gov/mhqcc/Documents/MDtelemedicne_reimbursementstudy.pdf.

[57] Technology Administration, Department of Commerce, *Innovation, Demand, and Investment in Telehealth,* February 2004. Available at: www.atp.nist.gov/eao/innovation_demand_invest_telehealth_022004.pdf.

[58] Medicare & Medicaid Research Review, *Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth,* Volume 3 (4), 2013. Available at: www.cms.gov/mmrr/Downloads/MMRR2013_003_04_a04.pdf.

[59] Center for Connected Health Policy, *IOM Report: The Role of Telehealth in an Evolving Health Care Environment, December 2012.* Available at: telehealthpolicy.us/sites/telehealthpolicy.us/files/uploader/IOM%20Telehealth%20Workshop%20Report%20Summary%202012.pdf.

[60] Medicare beneficiaries are eligible for telehealth services only if the services are presented from an originating site located in: a rural Health Professional Shortage Area, either located outside of a Metropolitan Statistical Area (MSA) or in a rural census tract, as determined by the Office of Rural Health Policy; or a county outside of a MSA. Sixty-three census tracts, or roughly 4.5 percent, out of 1,406 total census tracts in Maryland, are federally designated rural. A listing of Maryland Health Professional Shortage Areas is available at: hpsafind.hrsa.gov/HPSASearch.aspx. See Appendix J for a map of Maryland rural areas: hsia.dhmh.maryland.gov/opca/Documents/Map%20Rural%20Designation%202014.pdf.

[61] Centers for Medicare & Medicaid Services, *Telehealth Services: Rural Health Fact Sheet Series,* April 2014. Available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf. See Appendix K.

[62] Medicare is proposing the inclusion of additional services under the telehealth benefit in 2015, including annual wellness visits, psychotherapy, and prolonged evaluation and management services. Centers for Medicare & Medicaid Services, *Proposed policy and payment changes to the Medicare Physician Fee Schedule for Calendar Year 2015*, July 2014. Available at: cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-07-03-1.html?DLPage=1&DLSort=0&DLSortDir=descending.

[63] There are more than 10,000 Medicare services. More information about Medicare services is available at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How_to_MPFS_Booklet_ICN901344.pdf.

and improve patient care.[64, 65, 66, 67, 68] Medicare reimbursement generally includes telehealth consultations, screenings, and care coordination.

Telehealth reimbursement from Maryland Medicaid has recently expanded, although its use remains minimal. Legislation enacted in 2007 created a Maryland Medicaid reimbursement pilot for telemental health services. In 2013, the General Assembly expanded Medicaid reimbursement to two additional pilot programs: the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program.[69, 70] Law enacted in 2014 removed the pilot reimbursement limitation and expanded the Medicaid definition of telemedicine to include remote patient monitoring and store-and-forward technology when the State budget allows;[71] Medicaid proposed amended regulations for reimbursement of telemedicine services on October 3, 2014.[72] In 2013, only one hospital submitted approximately two telehealth claims to Medicaid, and roughly 4,450 telemental health claims were submitted to Medicaid by Federally Qualified Health Centers, mental health clinics, and physicians.[73] The Task Force did not evaluate Medicaid awareness initiatives to inform practitioners about the availability of telehealth reimbursement.

Telehealth Legislation

An estimated 44 states and the District of Columbia have adopted or proposed legislation aimed at expanding the use of telehealth.[74] Maryland has had legislation in place for many years to minimize barriers to telehealth adoption, yet utilization remains low. Legislation enacted in Maryland has mostly focused on reimbursement and credentialing and privileging of hospital physicians. Over the last two years, the General Assembly has enacted five laws to advance the use of telehealth:

- *Md. Insurance Code Ann. § 15-139*, *Health Insurance – Coverage for Services Delivered through Telemedicine*, requires health insurers and health maintenance organizations to provide coverage for health care services appropriately delivered through telehealth, and prohibits

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[64] Journal of Telemedicine and e-Health, *Telemedicine Reduces Discrepancies in Rural Trauma Care*, 2003. Volume 9 Number 1.
[65] Journal of Telemedicine and e-Health, *Rural Outreach in Home Telehealth: Assessing Challenges and Reviewing Successes*, 2006. Volume 12 Number 2.
[66] Journal of Telemedicine and e-Health, *Improving Stroke Outcomes in Rural Areas Through Telestroke Programs: An Examination of Barriers, Facilitators, and State Policies*, 2014 20(1).
[67] Journal of Telemedicine and e-Health, *TeleFIT: Adapting a Multidisciplinary, Tertiary-Care Pediatric Obesity Clinic to Rural Populations*, 2012, 18(3).
[68] Journal of Oncology Practice, *Extending Oncology Clinical Services to Rural Areas of Texas Via Technology*, 2012. Available at: jop.ascopubs.org/content/8/2/68.1.short.
[69] The Medicaid Program launched two telehealth programs - the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program. The new programs expand upon the Telemental Health Program, implemented in 2012. More information is available at: mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx.
[70] *Maryland Medical Assistance Program – Telemedicine*. Senate Bill 198 (Chapter 141) (2014 Regular Session). See Appendix C; available at: mgaleg.maryland.gov/2014RS/chapters_noln/Ch_141_sb0198T.pdf.
[71] *Maryland Medical Assistance Program – Telemedicine*. Senate Bill 198 (Chapter 141) (2014 Regular Session). See Appendix C; available at: mgaleg.maryland.gov/2014RS/chapters_noln/Ch_141_sb0198T.pdf.
[72] Maryland Register, proposed amendments to regulations .01—.07, .11, and .12 under COMAR 10.09.49 *Telemedicine Services*, October 3, 2014. Available online at: www.dsd.state.md.us/MDRegister/4120/Assembled.htm#_Toc399847133. See Appendix L for a copy of the proposed changes.
[73] Information obtained from the Maryland Department of Health and Mental Hygiene in June 2014.
[74] See Appendix M for State telehealth legislation tracking.

denial of coverage because a health care service was provided through telehealth rather than an in-person consultation.[75]

- *Md. Health-General Code Ann. § 19-319*, *Hospitals – Credentialing and Privileging Process – Telemedicine*, permits hospitals to, in credentialing and privileging process for a physician who provides medical services to the patients at the hospital only through telemedicine from a distant-site hospital or distant-site telemedicine entity, rely on the credentialing and privileging decisions made for the physician by the distant-site hospital or distant-site telemedicine entity.[76, 77]
- *Md. Health-General Code Ann. § 15-105.2*, *Maryland Medical Assistance Program – Telemedicine*, requires the Maryland Medical Assistance Program to provide reimbursement for certain services delivered through telehealth under certain circumstances.[78, 79]
- Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*, requires MHCC, in conjunction with the Council, to reconvene the Task Force and continue to study the use of telehealth in Maryland.[80]
- Senate Bill 198 (2014), *Maryland Medical Assistance Program – Telemedicine*, authorized the Department of Health and Mental Hygiene (DHMH) to allow coverage of and reimbursement for health care services delivered in a certain manner under certain circumstances.[81]

Maryland Physician Licensing Requirements for Telehealth

The Task Force identified two impediments to telehealth diffusion that relate to physician licensing requirements: physicians rendering telehealth services to patients in Maryland must obtain a license from the Maryland Board of Physicians (MBP); and physicians are required to establish a physician-patient relationship through face-to-face or real-time audio video conferencing before rendering care.[82, 83, 84] The MBP has adopted limited regulations governing the practice of telemedicine.[85] To assist states in formulating regulations for the rapidly evolving practice of telehealth, the Federation of State Medical Boards (FSMB) and the American Medical Association (AMA) each issued guidelines regarding telehealth (collectively, the 2014 guidelines) in the spring of 2014.

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[75] Md. Code Ann., Insurance § 15–139. See Appendix I.
[76] Md. Code Ann., Health - General § 19–319. See Appendix N.
[77] See Appendix O for Maryland credentialing regulations.
[78] Md. Code Ann., Health - General § 15–105.2. See Appendix P.
[79] See Appendix Q for Maryland Medicaid telemedicine regulations.
[80] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session); not codified in law. See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.
[81] *Maryland Medical Assistance Program – Telemedicine*. Senate Bill 198 (Chapter 141) (2014 Regular Session); not codified in law. See Appendix C; available at: mgaleg.maryland.gov/2014RS/chapters_noln/Ch_141_sb0198T.pdf.
[82] See Appendix R for more information about physician licensing.
[83] COMAR 10.32.05.05C. The regulations define *face-to-face* as *within each other's sight and presence*. COMAR 10.32.05.02B(2). The regulations define *real-time* to mean *simultaneously or quickly enough to allow two or more individuals to conduct a conversation*. COMAR 10.32.05.02B(7).
[84] An assessment of licensure challenges for non-physician health care practitioners was not conducted during the 2013 – 2014 Telemedicine Task Force.
[85] COMAR 10.32.05, *Telemedicine*.

Addressing the Maryland Telehealth Physician Licensure Challenge

An approach to mitigate the licensure impediment is for states to enter into an interstate compact that would facilitate multi-state physician licensing.[86] A compact coordinates policies across multiple states to address particular issues and adoption of similar regulatory requirements. A team of state medical board representatives and the Council of State Governments developed a framework for an *Interstate Medical Licensure Compact,* a licensing option for qualified physicians to practice in multiple states to be eligible for expedited licensure in all states participating in the compact.[87] The FSMB released model legislation for physician licensure compact in September 2014.[88] Under the proposed compact, participating state medical boards will retain their licensing and oversight of physicians who practice across state borders. Under the model legislation, participation in the compact would be voluntary for states and physicians.

Addressing the Maryland Physician-Patient Relationship Challenge

Maryland regulations define the physician-patient relationship as a *relationship between a physician and a patient in which there is an exchange of individual, patient-specific information*.[89] If the physician-patient relationship does not include prior in-person, face-to-face interaction with a patient, the physician must incorporate real-time auditory communications or real-time visual and audio communications to allow an exchange of information between the patient and the physician performing the patient evaluation.[90] One way to mitigate this barrier to telehealth diffusion is to revise what constitutes the establishment of a physician-patient relationship. The 2014 guidelines recommend the relationship be considered established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person, or through real-time communications.[91]

Maryland Telemedicine Task Force

The Task Force was originally established in 2010 by the Council to explore telehealth expansion in Maryland. A report on the work of the Task Force was completed in September 2010. The Task Force reconvened in 2011 at the request of then-Secretary of DHMH, John Colmers, with the establishment of three advisory groups to develop recommendations for increasing telehealth adoption: Clinical Advisory Group (CAG); Finance and Business Model (F&B) advisory group advisory group; and Technology Solutions and Standards (TSS) advisory group. A report on the

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[86] The U.S. Constitution grants states the ability to enter into multistate agreements, known as interstate compacts. Article 1, Section 10, Clause 3. U.S. Constitution.

[87] FSMB, *Interstate Medical Licensure Compact*, September 2014. Available at: www.fsmb.org/Media/Default/PDF/Advocacy/Interstate%20Medical%20Licensure%20Compact%20%28FINAL%29%20September%202014.pdf.

[88] FSMB, *Interstate Medical Licensure Compact*, September 2014. Available at: www.fsmb.org/Media/Default/PDF/Advocacy/Interstate%20Medical%20Licensure%20Compact%20%28FINAL%29%20September%202014.pdf.

[89] COMAR 10.32.05.02B(6).

[90] COMAR 10.32.05.05C. The regulations define *face-to-face* as *within each other's sight and presence*. COMAR 10.32.05.02B(2). The regulations define *real-time* to mean *simultaneously or quickly enough to allow two or more individuals to conduct a conversation*. COMAR 10.32.05.02B(7).

[91] In emergent situations, when patient consent cannot be obtained, a relationship could be considered established if a local health care provider, based on an assessment of the patient's condition, deems a telehealth consultation beneficial to the management of the patient.

2011 Task Force recommendations was completed in December 2011 and resulted in legislative changes.[92]

2014 Task Force

As required by 2013 law, the Task Force again reconvened in 2013 to study the expansion of telehealth. An interim report on the work was submitted to the Governor, the Senate Finance Committee, and the House Health and Government Operations Committee in December 2013.[93] The law also required a final report be submitted by December 1, 2014. The Task Force was comprised of public and private stakeholders and convened approximately 30 times between July 2013 and July 2014.[94, 95] About 90 individuals, representing roughly 65 organizations from both private and public sectors, participated in Task Force meetings.

The Task Force recommended telehealth use cases[96] as a way to accelerate diffusion and recommended that the General Assembly provide funding for the implementation of the use cases. The use cases aim to improve patient outcomes, reduce costs, and create a sustainable change in the way care is delivered. The funding, if appropriated, will be used to create innovative telehealth grants administered by MHCC. Lessons learned from the pilot project grants awarded to implement the use cases will inform future telehealth initiatives.

Telehealth Definition Recommendation

As previously noted, the definition of telemedicine that currently exists in law is restricted to real-time audio video communications. Telemedicine is currently defined as:

> *As it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care practitioner to deliver a health care service within the scope of practice of the health care practitioner at a site other than the site at which the patient is located.*[97]

The Task Force recommended a broader definition and substitution of the term *telehealth* as necessary to foster its use in innovative care delivery and payment models. Some expansion of the definition has already occurred during the 2014 legislative session; the definition of *telemedicine* in Maryland Medical Assistance was broadened to include reimbursement of store-and-forward technology or remote patient monitoring if the budget allows for the reimbursement of these services; Medicaid proposed amended regulations for reimbursement of telemedicine services on October 3, 2014.[98, 99] Since the expansion of the definition, Medicaid has not received financing to

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[92] MHCC, *Telemedicine Recommendations*, December 2011. Available at: mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TLMD_Recommend_rpt_20111201.pdf. See Appendix S for the recommendations.
[93] MHCC, *Maryland Telemedicine Task Force Interim Report*, December 2013. Available at: mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TTF_Interim_rpt_20131201.pdf.
[94] See Appendix T for the list of 2013 and 2014 Task Force meetings.
[95] See Appendix U for summaries of the 2013 and 2014 in-person Task Force meetings.
[96] Use cases are implemented through pilot projects narrow in scope that test the use case concepts before introducing them more widely.
[97] Md. Code Ann., Health - General § 19–319.
[98] Subject to limitations of the State budget and regulations.

include funding to reimburse these services. The Task Force recommended the General Assembly adopt the following definition to replace the current definition of telemedicine:[100]

> *Telehealth is the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner.*

Advisory Groups

The MHCC invited stakeholders to participate in the Task Force advisory groups and also encouraged public participation. The advisory groups had broad representation and included individuals with clinical, financial, and technical backgrounds. The law[101] identified categories for study by the Task Force, which were assigned to each of the advisory groups and are noted in each advisory group section.

Clinical Advisory Group

The CAG was chaired by H. Neal Reynolds, M.D., Associate Professor of Medicine, at the University of Maryland School of Medicine and Co-Director, of the Multi-Trauma Intensive Care Unit at the R. Adams Cowley Shock Trauma Center.[102, 103] The CAG was comprised of representatives from hospitals, health systems, ambulatory practices, payors, consumers, and State agencies, among others.[104] The CAG addressed the following categories from the 2013 law: the role of telehealth in advanced primary care delivery models; innovative service models for diverse care settings; use cases for evaluation; patient engagement, education, and goals; health professional productivity, resources, and shortages; and underserved population areas.[105, 106] The CAG developed guiding principles for the use cases that represent advantageous uses of telehealth in Maryland:[107]

- Increase patient access to care by aligning practitioner resources with population needs;
- Facilitate use of telehealth across the continuum of care from wellness to illness;
- Support prevention, management, and treatment of health conditions;
- Promote patient engagement and adherence to health care advice and medications;

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[99] Maryland Register, proposed amendments to regulations .01—.07, .11, and .12 under COMAR 10.09.49 *Telemedicine Services*, October 3, 2014. Available online at: www.dsd.state.md.us/MDRegister/4120/Assembled.htm#_Toc399847133. See Appendix L for a copy of the proposed changes.

[100] Adopting the Task Force's recommended definition of telehealth means that significant changes would need to be made to Maryland Medicaid to allow for or exclusion of reimbursement for the services encompassed in the new definition.

[101] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

[102] Robert R. Bass, M.D. former Executive Director of Maryland Institute for Emergency Medical Services Systems, chaired the CAG through December 2013 and subsequently retired.

[103] See Appendix V for a message from H. Neal Reynolds.

[104] See the *Acknowledgements* section for a list of participants in the Clinical Advisory Group.

[105] Task Force study topics were identified in *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session); not codified in law. See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf. The study topics were assigned to each of the advisory groups.

[106] See Appendix W for a list of discussion topics assigned to each advisory group to address the requirements of Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*.

[107] The innovative telehealth use cases provide broad examples of how telehealth can be used. Many of the telehealth use cases are already in practice in some capacity today.

- Facilitate use of existing telehealth technologies that are proven to be effective and cost-efficient, as well as allow for use of emerging technologies;
- Ensure alignment with health care reform efforts, including innovative payment models, such as Maryland's All-Payor Hospital System Modernization;[108] and
- Allow for development of granular use cases that are implementable, testable, and cost-effective.

Telehealth Use Cases

The CAG recommended telehealth use cases that it viewed as broad enough to enable various telehealth applications by most payors and practitioners.[109, 110] The CAG concluded that clinical guidelines will need to be developed by organizations using telehealth to identify the appropriateness of a telehealth intervention based on the patient's condition.[111, 112]

1. The use of telehealth to improve care coordination and transitions between long term and acute care settings.[113, 114] Comprehensive care facilities (CCFs)[115] often do not have24/7 access to primary care, psychiatric, and other health care services when needed. Telehealth will enable better coordinated care by virtually connecting a CCF with a physician and other support services.[116]

   Application Example: A nurse at a CCF uses audio video conferencing to connect to a hospitalist at night when the CCF does not have a physician on-site. The hospitalist provides an assessment of the CCF resident and, working with the nurse, the hospitalist is able to render the necessary care. In this application, telehealth results in timely medical intervention for the resident and the development of a treatment plan that enables the resident to remain in the CCF, saving the extra costs associated with a transfer and care at an acute care facility.

2. The use of telehealth facilitates management of patient conditions, as measured by hospital Prevention Quality Indicators (PQIs), after patients are discharged from a hospital for conditions that are likely to result in hospital readmissions, such as diabetes, hypertension, congestive heart failure, chronic obstructive pulmonary disease, and asthma.[117] These

[108] Beginning in 2014, Maryland hospitals operate under a global budget model where, among other things, they are required to manage the health of the population in their service area and reduce readmission rates. See Appendix X.
[109] See Appendix Y for potential clinical applications for the use cases and implementation considerations.
[110] A public comment period, including members of the F&B advisory group and TSS advisory group, was provided to offer the opportunity to provide feedback on the use cases. See Appendix Z for a list of comments received and changes made to the use cases during the public comment period of the development process.
[111] See Appendix A for an example of clinical guidelines for telehealth.
[112] See Appendix BB for telehealth standards and guidelines provided by the ATA.
[113] Care coordination refers to managing a patient's care by collaborating with other health care providers as needed, including nurses, physician assistants, pharmacists, nutritionists, social workers, and educators, specialists, hospitals, and community services.
[114] Long-term care refers to comprehensive care facilities, assisted living facilities, and independent living facilities.
[115] The term in Maryland law for a nursing home, sometimes also known as a Medicare skilled nursing facility (SNF).
[116] Health Affairs, *Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Residents and Generate Savings for Medicare,* February 2014.
[117] PQIs are national measures intended to help assess quality and access to care in communities. PQIs can be used with hospital discharge data to identify quality of care for conditions where outpatient care can potentially prevent complications or more severe disease. PQIs include: dehydration; urinary tract infections; perforated appendix; low birth

diseases cover a wide range of patient conditions where telehealth can improve care management and limit hospital readmission.[118, 119, 120, 121, 122]

Application Example: A high-risk patient is discharged from a hospital with recently uncontrolled diabetes (a PQI). The hospital equips the patient with a remote monitoring device to track blood glucose levels. The patient's primary care practitioner monitors data received electronically from the patient's remote monitoring device and is alerted by preset alarms to intervene. In this application, telehealth enables early intervention to address complications and prevent a hospital readmission.

3. The use of telehealth in hospital innovative service delivery models through ambulatory practice shared savings programs improves quality of care. Telehealth is a tool to render appropriate and timely care consistent with health reform models that place a strong emphasis on increasing access to care, mitigating practitioner shortages, improving patient outcomes, and enabling greater cost efficiency.[123, 124, 125, 126]

   Application Example: A practitioner at a primary care practice uses audio video conferencing to connect to a patient at home who is having non-life threatening symptoms such as a sore throat and back ache. The practitioner provides an assessment, performs the virtual exam of the patient, documents the encounter in an EHR, and sends the appropriate medication order electronically to the patient's pharmacy. In this application, telehealth allows for treatment of the patient at home without a visit to the emergency department.

4. The use of telehealth in value-based care delivery models increases access to care.[127] Telehealth is a tool to achieve the goals of value-based care delivery by decreasing

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weight; congestive heart failure; hypertension; adult asthma; chronic obstructive pulmonary disease, and others. More information is available at: www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx.

[118] The Veterans Health Administration has used telehealth, including remote monitoring and audio video conferencing, to provide chronic care management for diabetes, hypertension, congestive heart failure, and chronic obstructive pulmonary disease, as noted in Telemedicine and e-Health, *Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions,* December 2008.

[119] Clinical guidelines would need to be developed with criteria for each condition to specify when telehealth would be most beneficial to the patient. For example, not every patient admitted to the hospital with diabetic complications would require telehealth. Clinical guidelines will stipulate the situations where telehealth would be most effective.

[120] Home Health Care Management and Practice, *Impact of Home-Based Monitoring on the Care of Patients with Congestive Heart Failure*, October 2006. Available at: connected-health.org/media/112784/sue%20myers%20chf.pdf.

[121] The Clinical Respiratory Journal, *Nurse Tele-consultations with Discharged COPD Patients Reduce Early Readmissions – An Interventional Study*, January 2011.

[122] Journal of Telemedicine and e-Health, *Improvement in Asthma Symptoms and Quality of Life in Pediatric Patients through Specialty Care Delivered Via Telemedicine*, November 2001, Vol. 7(4).

[123] Honeywell, *Telehealth and Healthcare Reform: A White Paper*, July 2012. Available at: www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0CCAQFjAA&url=https%3A%2F%2Fwww.hommed.com%2Fwp-content%2Fuploads%2F2012%2F10%2FTelehealth-and-Healthcare-Reform-White-Paper_July-2012.pdf&ei=kkr7U9GCKMywyASGvYCYBQ&usg=AFQjCNEsrndcEMDXXnuKWbxPB4eTN-Hd2Q&bvm=bv.73612305,d.aWw&cad=rja.

[124] The National Law Review, *Health Care Reform: ACOs and Developments in Coordinated Care Delivery, Shared Savings and Bundled Payments*, 2011. Available at: www.himss.org/files/HIMSSorg/content/files/Code%203%20Health%20Care%20Reform%20ACOs%20and%20Developments%20in%20Coordinated%20Care%20Delivery,%20Shared%20Savings%20and%20Bundled%20Payments.pdf.

[125] Journal of Telemedicine and e-Health, *Critical Steps to Scaling Telehealth for National Reform*, November 2008.

[126] Advanced Medical Technology Association, *Telehomecare and Remote Monitoring: An Outcomes Overview*,

[127] See Appendix CC for an illustration of the concept of a PCMH that incorporates telehealth services in care delivery.

fragmentation of care, supporting health promotion and disease prevention, and addressing shortages of practitioners.[128]

Application Example: A patient with symptoms of depression visits a primary care practitioner in a PCMH practice. The primary care practitioner uses audio video conferencing to connect with a behavioral health specialist to conduct an assessment of the patient and provide recommendations for additional treatment. In this application, telehealth allows a patient to receive better access to behavioral health services without extreme waiting times that can occur in rural and underserved areas.

5. The use of telehealth in emergent telemedicine[129] during transport of critically ill patients increases care coordination. Telemedicine in emergent situations enables access to specialists who can assist in conducting diagnosis and treatment on-site or in transit to an acute care facility.[130]

   Application Example: An emergency medical technician (EMT) performs an evaluation at the scene of an accident, and suspects an injury that may directly impact the patient's outcome. Using audio-video conferencing to support existing emergency protocols, connect to a trauma surgeon, a virtual exam, review of physiologic data is performed, and the trauma surgeon advises the proper course of action. The trauma surgeon makes a tentative diagnosis, and directs the patient to the appropriate trauma center. In this application, the trauma surgeon directed the patient to the most appropriate medical facility, and accelerated the diagnostic process, thereby leading to earlier treatment and improved patient outcomes.

6. The use of telehealth for public health screening, monitoring, and documentation with data exchange, improves access to care, promotes disease prevention, and increases communication with primary care providers.[131] Telehealth supports practitioners in conducting public health screenings by enabling access to specialists, and in managing their patients' chronic health conditions.[132]

   Application Example: A nurse in a community-based clinic uses a digital retinal imaging device to screen for retinopathy. The nurse uses store-and-forward technology to send the retinal images to an ophthalmologist for review and diagnosis. In this application, telehealth allows for early detection and treatment of retinopathy and glaucoma thereby mitigating disabilities due to blindness and ultimately reducing the cost of medical care.

7. The use of telehealth in schools for screening and acute management of asthma, diabetes, childhood obesity, behavioral health, and smoking cessation improves health. Early life

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[128] Journal of Telemedicine and e-Health, *National Telemedicine Initiatives: Essential to Healthcare Reform*, 2009.
[129] The CAG noted the term *telemedicine* is appropriate for this use case category, as telemedicine would be needed for emergency situations, as opposed to telehealth.
[130] American College of Emergency Physicians, *Telehealth in Emergency Medicine: A Primer,* June 2014. More information is available at: www.acep.org/uploadedFiles/ACEP/Membership/Sections_of_Membership/telemd/ACEP%20Telemedicine%20Primer.pdf.
[131] Indian Journal of Community Medicine, *Telemedicine: A New Horizon in Public Health in India*, January 2008. Available at: www.ncbi.nlm.nih.gov/pmc/articles/PMC2782224/.
[132] Public health screening and monitoring can help with prevention and management of health conditions, such as diabetes, cancers, HIV/AIDS, tuberculosis, behavioral health, obesity, and dental health.

screening and intervention can decrease long term patient morbidity, promote wellness, reduce absenteeism, and reduce the need for hospitalization or hospital visits. Telehealth assists school-based practitioners in providing access to specialized health care services, nutritional counseling, behavioral health, and prevention and health education.[133]

Application Example: A guidance counselor or primary care practitioner at a school-based health center uses audio video technology to connect to an occupational therapist for assistance with a student experiencing episodic anxiety disorder. The occupational therapist assesses the student in consultation with the student's parent or guardian if appropriate and makes recommendations for cognitive behavioral therapy and social and emotional learning strategies that will help the student develop skills to manage behaviors that interfere with academic performance. In this application, telehealth supports early intervention and promotes the student's optimal educational achievement.

8. The use of telehealth for routine and high-risk pregnancies to improve access to specialized health care services for managing mild and/or early preeclampsia, gestational hypertension, and gestational diabetes mellitus, and preventing preterm-birth.[134] Use of telehealth services can be a cost-effective tool to improve pregnancy outcomes.[135]

   Application Example: An obstetrician with expertise in high risk pregnancy tracks, via remote monitoring, blood glucose levels, blood pressure and weight of a patient with gestational diabetes and a history of preeclampsia with her last pregnancy. When the blood glucose levels became elevated, hypertension develops and excessive weight gain is noted, the obstetrician uses audio-video conferencing to perform a remote exam, gathers more symptoms directly from the patient, and provides early interventions.

9. Widespread community site deployment of telehealth services connected to health care practitioners and/or the statewide HIE to increase access to health care services and transmission of health-related information, especially in underserved areas.[136] Remote monitoring and medical kiosks with telehealth services provide early intervention and prevent more acute health conditions.[137]

   Application Example: A patient with a skin rash visits a medical kiosk at a community pharmacy and connects to a dermatologist through audio video conferencing. The dermatologist diagnoses the condition as contact dermatitis and recommends over the counter topical treatment. The treatment plan is forwarded to the patient's primary care provider. In this application, telehealth enables the patient to receive timely care remotely.

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[133] ATA, *State Medicaid Best Practice: School-Based Telehealth,* July 2013. Available at: www.americantelemed.org/docs/default-source/policy/state-medicaid-best-practice---school-based-telehealth.pdf?sfvrsn=8.
[134] Journal of Telemedicine and Telecare, *The Effect of Telemedicine on Outcome and Quality of Life in Pregnant Women with Diabetes*, 2009.
[135] Managed Care Magazine, *Telemedicine: Cost-Effective Management of High-Risk Pregnancy*, November 2001.
[136] Medical kiosks can be installed in accessible locations, such as drug stores or community centers, to enable patients to interact with providers through audio video conferencing; remote monitoring devices can also be installed to stream biomedical information in real time to the virtual provider.
[137] Journal of Telemedicine and e-Health, *Community-Based Telemonitoring for Hypertension Management: Practical Challenges and Potential Solutions*, October 2011.

10. Remote mentoring, monitoring, and proctoring for the expansion, dispersion, and maintenance of skills, supervision, and education. Many studies show that telehealth helps practitioners learn critical skills in a variety of specialties.[138] Curricula for the training of current and future health care providers on the use of telehealth will need to be developed.[139]

    Application Example: A dental specialist transmits digital radiographic images remotely to guide a general dentist in the diagnosis and treatment of patients presenting with oral facial pain. Telehealth is used to ensure that dental specialty consultations can be obtained even when patients are not close to metropolitan areas where specialists often have practices. The dental specialist can, at a distance, review the patient's history, assess digital images, direct clinical examination, and develop in conjunction with the local dentist a diagnosis and treatment plan — thereby avoiding the potentially costly consequences for patients of not receiving timely, appropriate care for oral facial problems.

Finance and Business Model Advisory Group

The F&B advisory group was chaired by Ben Steffen, Executive Director of MHCC. The F&B advisory group was comprised of representatives from hospitals, health systems, ambulatory practices, payors, MedChi, The State Medical Society, long-term care, consumers, and State agencies, among others.[140, 141] The F&B advisory group explored the following categories from the 2013 law: innovative payment models; strategies for telehealth deployment to meet any increased demand for health care due to the implementation of the PPACA; public and private grant funding; and applications for cost-effective telehealth.[142]

Key financial and business model challenges of deploying the use cases were identified by the F&B advisory group. The challenges center on reimbursement structure; remote facility and delivery site billing; practitioner availability, monitoring, and care coordination; practice transformation and redesign; and timeframes for implementation.[143, 144] The F&B advisory group considered proposing solutions to address the challenges, and concluded that, at this time, statewide policy would inhibit innovation in the deployment of the use cases. The F&B advisory group emphasized that organizations deploying the use cases need to develop solutions unique to their organization and patient population to mitigate the challenges. It is expected that implementation of the use cases will identify challenges specific to certain business models or types of practitioners, which may warrant suggestions for statewide policy in the future. Absent addressing the financial and

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[138] Journal of Telemedicine and e-Health*, Medical Connectivity,* April 2011.
[139] Medicaid cannot reimburse for health education and communication between providers; Medicaid reimbursement is restricted to general consult with patient present.
[140] See the Acknowledgements section for a list of participants in the Clinical Advisory Group.
[141] See Appendix W for a list of discussion topics assigned to each advisory group to address the requirements of Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*.
[142] Task Force study topics were identified in *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session); not codified in law. See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf. The study topics were assigned to each of the advisory groups.
[143] See Appendix DD for finance and business model challenges of implementing the use cases.
[144] Members of the CAG and TSS advisory group had the opportunity to provide feedback on the use cases. See Appendix EE for a list of comments received and changes made regarding the finance and business model challenges during the public comment period of the development process.

business model challenges, sustainability of the use cases is unlikely when funding, such as grants or venture capital, is depleted.

Technology Solutions and Standards Advisory Group

The TSS advisory group was chaired by David Sharp, Director, Center for Health Information Technology & Innovative Care Delivery, MHCC, and included representatives from health systems, hospitals, law firms, ambulatory practices, technology vendors, consumers, the Rural Maryland Council, State agencies, and CRISP, among others.[145] The TSS advisory group evaluated the following categories from the law: emerging technology and standards for security; strategies for telehealth deployment in rural areas to increase access to health care; and supportive uses of EHRs and HIE.[146] The TSS advisory group determined the use cases that could be implemented with existing telehealth technology and identified existing barriers to telehealth diffusion as the lack of availability of information about practitioners rendering telehealth services and interoperability with other telehealth provider systems.

The TSS advisory group focused on developing a publicly available online telehealth provider directory (telehealth directory).[147, 148, 149] The telehealth directory will be a statewide centralized listing of telehealth practitioners and provide information about available telehealth services. Participation in the telehealth directory will be voluntary. Implementing a telehealth directory will require at least a year, and managing the information in the telehealth directory will be ongoing. Once implemented, the telehealth directory will enhance telehealth by serving as a resource to identify telehealth practitioners. The telehealth directory is envisioned to include a search feature for consumers and practitioners to look up select information, such as:

- Telehealth capabilities, e.g., a scheduled real-time virtual consultation, store-and-forward or image review;
- Specialty for which telehealth services are being provided, e.g., behavioral health or dermatology;
- EHR product to enable electronic exchange of health information;
- Contact details, e.g., phone number, email address;
- Biographical information, e.g., professional background and credentials;
- Insurance information, e.g., payors; and
- Scheduling availability, e.g., days and times.

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[145] See the Acknowledgements section for a list of participants in the Technology Solutions and Standards Advisory Group.
[146] Task Force study topics were identified in uncodified law in *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session. See Appendix A; available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf. The study topics were assigned to each of the advisory groups.
[147] See Appendix FF for wireframe concepts illustrating information to be included in the telehealth directory.
[148] Members of the CAG and F&B advisory group had the opportunity to provide feedback on the wireframe concepts. See Appendix GG for a list of comments received and changes made to the wireframe concepts during the public comment period of the development process.
[149] See Appendix HH for potential telehealth directory features that were explored by the TSS advisory group and were generally agreed not to be appropriate for inclusion.

The telehealth directory will be made available through the State-Designated HIE. All 46 general acute care hospitals transmit to CRISP laboratory, radiology, and transcribed reports. In addition to hospitals, CRISP also receives information from nine long-term care facilities, eight radiology facilities, and two laboratories. CRISP enables the availability of clinical information to its participating organizations through a variety of HIE services. One service CRISP provides is a web-based provider directory that could be expanded to include telehealth information. The existing CRISP provider directory includes over 36,000 practitioners and lists practitioner name, specialty, health plans accepted, office location(s), and phone number(s). If the telehealth directory is funded, it will be populated through modifications to the CRISP participating organization registration process. Information contained in the directory will be self-reported and updated by participating organizations. Implementing the telehealth directory is anticipated to require about $270,000 and approximately $60,000 annually to maintain.[150] While the initial investment in the telehealth directory is included in the $2.5 million funding request, the identification of a funding source will be required to maintain the telehealth directory. In addition to the telehealth directory, CRISP is exploring offering image exchange capabilities pending award of federal funding, which could increase the use of store-and-forward telehealth technology.

Advancing Telehealth in Maryland

Recommendation for Use Case Implementations

The Task Force requests that the General Assembly make available $2.5 million in funding to support the implementation in pilot projects of select telehealth use cases.[151] The MHCC does not have funding for the telehealth use cases in its budget; a funding source identified by the General assembly is required. Funding appropriated by the General Assembly would be used by MHCC to award pilot projects grants. Grant applications for use cases in underserved and/or rural areas to increase access to care and to improve patient outcomes will be encouraged. Funding will support infrastructure and technology investments. An additional funding source is required to support the telehealth directory when the grant funds are depleted. The lessons learned will be used to inform the design of future telehealth programs in Maryland. Absent funding from the General Assembly for use case implementations, the use of telehealth will remain limited and fragmented.

If funding is available, MHCC will determine funding amounts for each use case based on the grant applications and the strength of the proposals made in the application. Some grant applicants may request initial investment funds and some grant applicants may request funding to support expansion of existing telehealth programs. Grants will be structured as two-year partnerships with MHCC. Grant applications will require, among other things, the following:

- Quality measures, including patient satisfaction, and goals that can be assessed pre- and post-implementation of the telehealth technology pilot;
- An assessment of clinical workflow and technology necessary to make the intervention successful;

[150] An estimated budget for the implementation and maintenance of the telehealth provider directory is available in Appendix II.
[151] Public comments received to the draft report and responses are available in Appendix JJ.

- Analysis of cost savings as a result of the use case;
- Prospects for sustainability that include plans for continuation or replication of the use case; and
- Matching funds with an increasing level of match required each year of the project with the goal of achieving self-sufficiency (e.g. Project Year 1 - $1 match for each $10 grant; Project Year 2 - $1 match for each $7 grant).

The use cases will incorporate best practices and lessons learned from three hospital and CCF projects that MHCC began in October 2014 to implement the first use case category: *improve transitions of care between acute and post-acute settings through telehealth.*[152] The nine-month pilots are scheduled for completion in the fall of 2015. Funding per award is up to $30,000 and requires a dollar for dollar match from applicants. The pilots will assess the impact of telehealth on hospital emergency room visits, admissions, and readmissions from a CCF to a general acute care hospital. The awardees are required to use an EHR and CRISP services. The three projects are summarized as follows:

1) Atlantic General Hospital Corporation, in partnership with Berlin Nursing and Rehabilitation Center (Berlin), began a pilot project titled *Reducing Readmissions in Nursing Home Patients via Telemedicine*. The goal is to reduce both acute care hospital costs and transportation costs associated with hospital admissions and readmissions from Berlin. Hospital physicians will provide remote care to Berlin residents using telehealth technology. The application requested $30,000 in grant funding and intends to supply a matching contribution of $87,922.

2) Dimensions Healthcare System, in partnership with Sanctuary of Holy Cross, began a pilot project titled *Integrating Virtual Visits and Remote Monitoring to Improve Transitions of Care between Dimensions Healthcare System Facilities and Comprehensive Care Facilities*. The goal is to improve transitions of care for residents at Sanctuary of Holy Cross through virtual consultations and remote monitoring between Dimensions Healthcare System hospitalists and Sanctuary of Holy Cross providers for residents with pneumonia and heart failure. The application requested $30,000 in grant funding and intends to supply a matching contribution of $32,000.

3) University of Maryland Upper Chesapeake Health (Upper Chesapeake), in partnership with the Bel Air facility of Lorien Health Systems (Lorien), began a pilot project titled *UMUCH-Lorien- LifeBot Telehealth Pilot*. The goal is to reduce avoidable hospital utilization originating from Lorien. Using telehealth technology, Upper Chesapeake will extend emergency medical management expertise to Lorien 24 hours a day. Real-time data on residents' vital signs will be transmitted between Upper Chesapeake and Lorien; providers involved in the telehealth pilot will assess residents and identify appropriate treatment plans. Treatment protocols will be developed to standardize the determination of when Lorien should initiate a virtual visit with an Upper Chesapeake provider. The application requested $27,888 in grant funding and intends to supply a matching contribution of $27,888.

[152] See Appendix KK for the telehealth pilot grant application announcement.

Remarks

Telehealth provides the opportunity to enhance the patient experience and improve patient outcomes by increasing access to care. As Maryland continues to implement health care reform, the use of telehealth will become progressively more relevant. Over the last four years, the Task Force has made notable progress in identifying and mitigating barriers to telehealth adoption and use. The Task Force recommendations, if implemented, are expected to improve quality of care, help contain health care costs, and increase patient and provider satisfaction.

There is growing interest in telehealth use among payors, practitioners, health care patients, and consumers as technology progresses and health care reform goals are achieved. Telehealth is viewed as a component of improving health care delivery and addressing inequities in access to care. Implementing telehealth is a complex and evolving endeavor.[153] Collaboration among stakeholders is essential in implementing the use cases to foster more rapid diffusion of telehealth. Evidence from the pilot projects implementations of the use cases will be compiled by MHCC to inform future telehealth policy.

[153] Journal of Telemedicine and e-Health, *National Telemedicine Initiatives: Essential to Healthcare Reform*, 2009.

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The MHCC appreciates the voluntary contributions made by stakeholders who participated in the Task Force. Participation in the Task Force was laudable; about 90 people devoted a considerable amount of their time to formulate the recommendations included in the report. The MHCC acknowledges and thanks the following Task Force participants for their dedication to this important work:

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Appendix A: Senate Bill 776 (Chapter 319) (2013)

Begin quoted text

Chapter 319

(Senate Bill 776)

AN ACT concerning

~~**Task Force on the Use of Telehealth to Improve Maryland Health Care**~~

Telemedicine Task Force – Maryland Health Care Commission

FOR the purpose of ~~establishing the Task Force on the Use of Telehealth to Improve Maryland Health Care; providing for the membership, co–chairs, and staffing of the Task Force; providing for the duties of the Task Force; providing that a member of the Task Force may not receive certain compensation but is entitled to certain reimbursement; requiring the Task Force to provide certain reports to the Governor and the General Assembly on or before certain dates; providing for the termination of this Act; and generally relating to the Task Force on the Use of Telehealth to Improve Maryland Health Care~~ *declaring the intent of the General Assembly that the Maryland Health Care Commission, in conjunction with the Maryland Health Quality and Cost Council, continue to study the use of telehealth throughout the State through the Telemedicine Task Force; requiring the Task Force to consist of certain advisory groups and undertake certain activities; and requiring the Commission, on or before certain dates, to submit certain reports of the Task Force to the Governor and certain legislative committees*.

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That:

~~(a) There is a Task Force on the Use of Telehealth to Improve Maryland Health Care.~~

~~(b) The Task Force consists of the following members:~~

~~(1) one member of the Senate of Maryland, appointed by the President of the Senate;~~

~~(2) one member of the House of Delegates, appointed by the Speaker of the House;~~

~~(3) the Secretary of Health and Mental Hygiene, or the Secretary's designee;~~

~~(4) the Director of the Department of Health and Mental Hygiene's Office of Rural Health, or the Director's designee;~~

~~(5) the Director of Program Development for the Maryland Critical Care Network~~ Vice ~~President of Telemedicine – University of Maryland Medical System, or the Director's~~ Vice ~~President's designee;~~

~~(6) the Executive Director of the Maryland Health Care Commission, or the Executive Director's designee;~~

~~(7) the Executive Director of the Rural Health Association, or the Executive Director's designee;~~

~~(8) the Executive Director of the Rural Maryland Council, or the Executive Director's designee;~~

~~(9) the Executive Director of the Maryland Institute for Emergency Medical Services Systems, or the Executive Director's designee; and~~

~~(10) the following members, appointed by the Governor:~~

~~(i) two representatives from the medical communities~~ organizations ~~that serve medically underserved populations in the State or are located in provider shortage underserved areas across the State that include both rural and urban areas;~~

~~(ii) two consumers or representatives of consumer advocate organizations;~~

~~(iii) one representative from the State health information exchange;~~

~~(iv) two representatives of the health insurance industry;~~

~~(v) two representatives from roundtables established in the State to study telehealth;~~

~~(vi) one representative from the State's Telemedicine Task Force of 2011;~~

~~(vii) one individual who provides home health care through telemedicine;~~

~~(viii) one individual who provides care through a patient–centered medical home;~~

~~(ix) one individual who provides acute care through telemedicine;~~

~~(x) one licensed psychiatrist;~~

~~(xi) one licensed provider of behavioral health services;~~

~~(xii) one representative of a hospital that is participating in telemedicine; and~~

~~(xiii) one representative of the Governor's Workforce Investment Board;~~

~~(xiv) two representatives of Federally Qualified Health Centers, including one from a center in a rural area and one from a center in an urban area;~~

~~(xv) one representative of the Maryland Chamber of Commerce; and~~

~~(xvi) one representative of the Arc of Maryland.~~

~~(c) The members appointed by the Presiding Officers of the General Assembly shall co–chair the Task Force.~~

~~(d) The Maryland Health Care Commission shall provide staff for the Task Force.~~

~~(e) A member of the Task Force:~~

~~(1) may not receive compensation as a member of the Task Force; but~~

~~(2) is entitled to reimbursement for expenses under the Standard State Travel Regulations, as provided in the State budget.~~

~~(f) The Task Force shall:~~

~~(1) identify opportunities to use telehealth to improve health status and health care delivery in the State, including an analysis of:~~

~~(i) underserved populations and areas;~~

~~(ii) applications for cost–effective telehealth;~~

~~(iii) innovative service models for diverse care settings to include chronic and acute care; and~~

~~(iv) innovative payment models; and~~

~~(v) the types of telehealth services that are resulting, or would result, in cost–effective care and improved outcomes for patients in the Medicaid program;~~

~~(2) assess factors related to telehealth, including an analysis of:~~

~~(i) supportive uses of electronic health records and the health information exchange;~~

~~(ii) multimedia uses of products and services for patient engagement, education, and outcomes;~~

~~(iii) health professional productivity, resources, and shortages;~~

~~(iv) emerging technology and standards for security; and~~

~~(v) public and private grant funding; and~~

~~(vi) whether the term "telemedicine", as defined in § 15–139 of the Insurance Article, should be amended to include a reference to a service, known as an "electronic visit" or "e–visit", that:~~

~~1. includes an online medical evaluation and management service;~~

~~2. is completed using a HIPAA–compliant online connection and a secured Web site or secured electronic mail address for each patient encounter; and~~

~~3. creates a permanent record of each visit;~~

~~(3) collaborate with:~~

~~(i) roundtables established to study telehealth uses in the State;~~

~~(ii) the Rural Maryland Council; and~~

~~(iii) any other organization that the co–chairs of the Task Force consider appropriate;~~

~~(4) review and consider any studies, reports, or other work completed by the roundtables;~~

~~(5) study any other topic that the Task Force finds necessary to make recommendations regarding the use of telehealth in the State; and~~

~~(6) make recommendations regarding the use of telehealth in the State, including recommendations for:~~

~~(i) improving health care affordability, accessibility, and quality;~~

~~(ii) developing a model for statewide telehealth infrastructure, service, and access;~~

~~(iii) utilizing public and private grant funding;~~

~~(iv) providing workforce training; and~~

~~(v) improving public health.~~

~~(g) (1) On or before May 1, 2014 December 1, 2013, the Task Force shall provide an interim report on the status of the activities of the Task Force to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly.~~

~~(2) On or before December 1, 2014 2015, the Task Force shall provide a final report on its findings and recommendations to the Governor and, in accordance with § 2–1246 of the State Government Article, the General Assembly.~~

(a) It is the intent of the General Assembly that the Maryland Health Care Commission, in conjunction with the Maryland Health Quality and Cost Council, continue to study the use of telehealth throughout the State through the Telemedicine Task Force.

(b) The Task Force shall:

(1) consist of three existing advisory groups:

(i) the clinical advisory group;

(ii) the technology solutions and standards advisory group; and

(iii) the financial and business model advisory group;

(2) identify opportunities to use telehealth to improve health status and care delivery in the State that includes an analysis of:

(i) underserved population areas;

(ii) applications for cost–effective telehealth;

(iii) innovative service models for diverse care settings to include chronic and acute care; and

(iv) innovative payment models;

(3) assess factors related to telehealth that includes an analysis of:

(i) supportive uses of electronic health records and health information exchange;

(ii) multimedia uses of products and services for patient engagement, education, and outcomes;

(iii) health professional productivity, resources, and shortages;

(iv) emerging technology and standards for security; and

(v) public and private grant funding;

(4) identify strategies for telehealth deployment in rural areas of the State to increase access to health care and meet any increased demand for health care due to the implementation of the Patient Protection and Affordable Care Act; and

(5) study any other topic the Maryland Health Care Commission finds necessary to make recommendations regarding the use of telehealth in the State.

(c) The Maryland Health Care Commission shall submit to the Governor and, in accordance with § 2–1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee:

(1) on or before January 1, 2014, an interim report of the Task Force findings and recommendations; and

(2) on or before December 1, 2014, a final report of the Task Force findings and recommendations.

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect ~~October~~ June July 1, 2013. It shall remain effective for a period of ~~1 year and 8 months~~ 3 2 years and, at the end of ~~May 31~~ June 30, ~~2015~~ 2016 2015, with no further action required by the General Assembly, this Act shall be abrogated and of no further force and effect.

Approved by the Governor, May 2, 2013.

End quoted text

Appendix B: Glossary

Telecare: Telecare is a term given to offering remote care of elderly and vulnerable people, providing the care and reassurance needed to allow them to remain living in their own homes. Continuous, automatic and remote monitoring to manage the risks associated with independent living (American Telemedicine Association).

Teleconsultation: Consultation between a provider and specialist at distance using either store and forward telemedicine or real time videoconferencing (American Telemedicine Association).

Telehealth: Telehealth is the delivery of health education and services using telecommunications and related technologies in coordination with a health care practitioner (2014 Maryland Telemedicine Task Force).

Telelearning: A telelearning system facilitates the provision of education and training services to health care professionals or patients. It is typically a room-based videoconferencing system with some additional attachments, such as a scanner, VCR, a document camera or a computer (American Telemedicine Association).

Telemedicine: Telemedicine as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located (Maryland law).

Telementoring: The use of audio, video, and other telecommunications and electronic information processing technologies to provide individual guidance or direction. An example of this help may involve a consultant aiding a distant clinician in a new medical procedure (American Telemedicine Association).

Telemonitoring: The process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance (American Telemedicine Association).

Telepresence: The method of using robotic and other instruments that permit a clinician to perform a procedure at a remote location by manipulating devices and receiving feedback or sensory information that contributes to a sense of being present at the remote site and allows a satisfactory degree of technical achievement. For example, this term could be applied to a surgeon using lasers or dental hand pieces and receiving pressure similar to that created by touching a patient, so that it seems as though the patient is actually present, permitting a satisfactory degree of dexterity (American Telemedicine Association).

Teleproctoring: Teleproctoring refers to the supervision of an examination from a distance using telecommunication technology (Society of American Gastrointestinal and Endoscopic Surgeons).

Appendix C: Senate Bill 198 (Chapter 141) (2014)

Begin quoted text

Chapter 141

(Senate Bill 198)

AN ACT concerning

Maryland Medical Assistance Program – Telemedicine

FOR the purpose of ~~requiring the Maryland Medical Assistance Program to provide certain reimbursement for certain services delivered by telemedicine~~ requiring, to the extent authorized by federal law or regulation, certain provisions of law relating to coverage of and reimbursement for health care services delivered through telemedicine to apply to the Maryland Medical Assistance Program and managed care organizations in a certain manner; authorizing the Department of Health and Mental Hygiene to allow coverage of and reimbursement for health care services delivered in a certain manner under certain circumstances; authorizing the Department to specify by regulation the types of health care providers eligible to receive certain reimbursement; repealing the limitations on the health care services delivered by telemedicine that are eligible for reimbursement; defining certain terms; and generally relating to the Maryland Medical Assistance Program and telemedicine.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 15–105.2
Annotated Code of Maryland
(2009 Replacement Volume and 2013 Supplement)

~~BY repealing and reenacting, without amendments,~~
~~Article – Insurance~~
~~Section 15–139(a)~~
~~Annotated Code of Maryland~~
~~(2011 Replacement Volume and 2013 Supplement)~~

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

15–105.2.

(a) The Program shall reimburse health care providers in accordance with the requirements of Title 19, Subtitle 1, Part IV of this article.

(b) ~~[(1) Subject to paragraph (2) of this subsection and unless]~~ **UNLESS** ~~otherwise specifically prohibited or limited by federal or State law, the Program shall reimburse a health care provider for a health care service delivered by telemedicine, as defined in § 15–139 of the Insurance Article, in the same manner as the same health care service is reimbursed when delivered in person.~~

~~[(2) Reimbursement under paragraph (1) of this subsection is required only for a health care service that:~~

~~(i) Is medically necessary; and~~

~~(ii) Is provided:~~

~~1. For the treatment of cardiovascular disease or stroke;~~

~~2. In an emergency department setting; and~~

~~3. When an appropriate specialist is not available.~~

(1) (I) IN THIS SUBSECTION THE FOLLOWING WORDS HAVE THE MEANINGS INDICATED.

(II) "HEALTH CARE PROVIDER" MEANS A PERSON WHO IS LICENSED, CERTIFIED OR OTHERWISE AUTHORIZED UNDER THE HEALTH OCCUPATIONS ARTICLE TO PROVIDE HEALTH CARE IN THE ORDINARY COURSE OR BUSINESS OR PRACTICE OF A PROFESSION OR IN AN APPROVED EDUCATION OR TRAINING PROGRAM.

(III) 1. "TELEMEDICINE" MEANS, AS IT RELATES TO THE DELIVERY OF HEALTH CARE SERVICES, THE USE OF INTERACTIVE AUDIO, VIDEO, OR OTHER TELECOMMUNICATIONS OR ELECTRONIC TECHNOLOGY:

A. BY A HEALTH CARE PROVIDER TO DELIVER A HEALTH CARE SERVICE THAT IS WITHIN THE SCOPE OF PRACTICE OF THE HEALTH CARE PROVIDER AT A SITE OTHER THAN THE SITE AT WHICH THE PATIENT IS LOCATED; AND

B. THAT ENABLES THE PATIENT TO SEE AND INTERACT WITH THE HEALTH CARE PROVIDER AT THE TIME THE HEALTH CARE SERVICE IS PROVIDED TO THE PATIENT.

2. "TELEMEDICINE" DOES NOT INCLUDE:

A. AN AUDIO–ONLY TELEPHONE CONVERSATION BETWEEN A HEALTH CARE PROVIDER AND A PATIENT;

B. AN ELECTRONIC MAIL MESSAGE BETWEEN A HEALTH CARE PROVIDER AND A PATIENT; OR

C. A FACSIMILE TRANSMISSION BETWEEN A HEALTH CARE PROVIDER AND A PATIENT.

(2) TO THE EXTENT AUTHORIZED BY FEDERAL LAW OR REGULATION, THE PROVISIONS OF § 15–139(C) THROUGH (F) OF THE INSURANCE ARTICLE RELATING TO COVERAGE OF AND REIMBURSEMENT FOR HEALTH CARE SERVICES DELIVERED THROUGH TELEMEDICINE SHALL APPLY TO THE PROGRAM AND MANAGED CARE ORGANIZATIONS IN THE SAME MANNER THEY APPLY TO CARRIERS.

(3) SUBJECT TO THE LIMITATIONS OF THE STATE BUDGET AND TO THE EXTENT AUTHORIZED BY FEDERAL LAW OR REGULATION, THE DEPARTMENT MAY AUTHORIZE COVERAGE OF AND REIMBURSEMENT FOR HEALTH CARE SERVICES THAT ARE DELIVERED THROUGH STORE AND FORWARD TECHNOLOGY OR REMOTE PATIENT MONITORING.

(4) THE DEPARTMENT MAY SPECIFY BY REGULATION THE TYPES OF HEALTH CARE PROVIDERS ELIGIBLE TO RECEIVE REIMBURSEMENT FOR HEALTH CARE SERVICES PROVIDED TO PROGRAM RECIPIENTS UNDER THIS SUBSECTION.

~~(3)~~ **(5)** The Department shall adopt regulations to carry out this subsection~~.~~**]**

~~**Article – Insurance**~~

~~15–139.~~

~~(a) (1) In this section, "telemedicine" means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.~~

~~(2) "Telemedicine" does not include:~~

~~(i) an audio–only telephone conversation between a health care provider and a patient;~~

~~(ii) an electronic mail message between a health care provider and a patient; or~~

~~(iii) a facsimile transmission between a health care provider and a patient.~~

SECTION 2. AND BE IT FURTHER ENACTED, That this Act shall take effect October 1, 2014.

Approved by the Governor, April 14, 2014.

End quoted text

Appendix D: 2013 Telemedicine Task Force Interim Report

State law required the Maryland Health Care Commission (MHCC) to reconvene the Telemedicine Task Force (Task Force) to identify opportunities for expanding telemedicine to improve health status and care delivery.[154, 155] The law also required MHCC to update the Governor, Senate Finance Committee, and the House Health and Government Operations Committee on the work of the Task Force by the end of 2013. The following is the interim report on the work of the Task Force. Appendices were not included in the following quoted text; for a copy of the report in its entirety, visit:
mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TTF_Interim_rpt_20131201.pdf.

Begin quoted text

Overview

Telemedicine adoption is fragmented in Maryland. Diffusion of the technology in acute care hospitals is about 46 percent as opposed to roughly 10 percent among physicians.[156, 157] Existing law requires State-regulated payors to reimburse for telemedicine services when certain conditions are met.[158, 159] In general, providers have been slow to take advantage of the law. Over the last nine months, only about 50 providers submitted roughly 78 telemedicine claims to State-regulated payors.[160] In comparison, government payors limit telemedicine reimbursement. Medicare provides reimbursement for about 60 evaluation and management services within certain rural areas of the State. Medicaid reimbursement is restricted to two pilot programs.[161]

Existing fee-for-service models incentivize episodic care and do not provide incentives for the investment in new models of care delivery. The Patient Protection and Affordable Care Act (ACA) fosters innovative care delivery models that incentivize providers to improve quality and efficiency of health care based on patient outcomes rather than volume of services provided. The use of telemedicine can support innovative care delivery models by improving health care quality and

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[154] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at Appendix A and: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

[155] Telemedicine can help improve access to health care services, enhance the patient care experience, improve population health, and reduce costs. Telemedicine, as currently defined in Md. Code Ann., Insurance § 15–139, means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient. See Appendix B for a glossary of terms.

[156] Maryland Health Care Commission, *Health Information Technology: An Assessment of Maryland Hospitals*, September 2013. Available at:
http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Hosp_HealthIT_Assess_MD_Rpt_20130901.pdf.

[157] 2012 Board of Physician Licensure file, a database of physician responses to the bi-annual licensure survey.

[158] Md. Code Ann., Insurance § 15–139. See Appendix H.

[159] For more information on State laws related to reimbursement, see the American Telemedicine Association, *State Telemedicine Legislation Tracking,* 2013 in Appendix D.

[160] The largest four State-regulated payors reported roughly 78 claims were submitted for services rendered through telemedicine from the time the law was enacted on October 1, 2012 through June 30, 2013. State-regulated payors indicated that it is possible that providers are rendering services through telemedicine and are not using the modifier in claims submission.

[161] The Maryland Department of Health and Mental Hygiene's Medical Assistance (Medicaid) Program launched two programs - the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program - to improve participant access to consulting Medicaid providers when an appropriate specialist is not available to provide a timely consultation. The new programs expand upon the Telemental Health Program, implemented in 2012. More information is available at: https://mmcp.dhmh.maryland.gov/SitePages/Provider%20Information.aspx.

patient outcomes while reducing cost. Despite the potential of telemedicine to enhance the way care is delivered, it is not expected to increase significantly absent widespread adoption of value-based care.

State law requires the Maryland Health Care Commission (MHCC) to reconvene the Telemedicine Task Force (Task Force) to identify opportunities for expanding telemedicine to improve health status and care delivery.[162, 163] The law also requires MHCC to update the Governor, Senate Finance Committee, and the House Health and Government Operations Committee on the work of the Task Force by the end of 2013. This is an interim report on the work of the Task Force; the final report that is due December 1, 2014 will include recommendations aimed at increasing the use of telemedicine.

Over the last several months, the Task Force has explored options that could facilitate expanded use of telemedicine in innovative care delivery models. The Clinical Advisory Group and the Technology Solutions and Standards Advisory Group of the Task Force met nine times.[164] The advisory groups are currently contemplating telemedicine use cases and the development of a provider registry aimed at identifying telemedicine providers and the technology they use. In 2014, the Task Force intends to finalize recommendations pertaining to the technology required to support a telemedicine registry; use cases to be implemented in a phased approach beginning in underserved and rural areas; and care delivery models leading to the adoption of telemedicine.

Limitations

This is an interim report on the work underway by the Task Force. The report is intended to provide the Governor and General Assembly with an update of activities, and it does not include recommendations for legislative action. Information included in the interim report is based on the nine meetings that occurred in 2013.

Task Force Background

The Task Force was originally convened in 2010 to identify opportunities for expanding telemedicine to improve health status and care delivery in the State.[165] At the request of John Colmers, the former Secretary of the Maryland Department of Health and Mental Hygiene, the Task Force reconvened in 2011 to develop additional recommendations for advancing telemedicine, and three advisory groups were established: Clinical; Technology Solutions and Standards; and Finance

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[162] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at Appendix A and: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.

[163] Telemedicine can help improve access to health care services, enhance the patient care experience, improve population health, and reduce costs. Telemedicine, as currently defined in Md. Code Ann., Insurance § 15–139, means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient. See Appendix B for a glossary of terms.

[164] See Appendix F for the Task Force 2013 meeting schedule.

[165] The Task Force was convened in response to a report by the Maryland Department of Health and Mental Hygiene, *Improving Stroke Care through Telemedicine in Maryland* as well as the recommendations of the Maryland State Advisory Council on Heart Disease and Stroke as stated in their biannual report to the Governor in both 2007 and 2009.

and Business Model. The work of the 2011 Task Force was outlined in the December 2011 report, *Telemedicine Recommendations*, that was presented to the Maryland Quality and Cost Council.[166]

Law enacted in 2012 required State-regulated payors to reimburse for services delivered through telemedicine.[167] In 2013, three laws intended to minimize the barriers to telemedicine adoption were passed, which include:[168]

- Senate Bill 798 (2013), *Hospitals – Credentialing and Privileging Process – Telemedicine*, enables hospitals to rely on certain credentialing and privileging decisions made by a distant site hospital or telemedicine entity;[169,170]
- Senate Bill 496 (2013), *Maryland Medical Assistance Program – Telemedicine*, requires the Maryland Medical Assistance Program to provide reimbursement for certain services delivered through telemedicine under certain circumstances; and[171,172]
- Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*,(SB 776) requires MHCC, in conjunction with the Maryland Health Quality and Cost Council, to reconvene the Task Force.[173]

Maryland Telemedicine Adoption

Telemedicine diffusion in Maryland has been slow and fragmented.[174] In 2012, about 46 percent of Maryland acute care hospitals reported using telemedicine, and adoption among Maryland physicians has been lower at approximately 10 percent.[175, 176] State-regulated payors have indicated that only about 78 claims have been process for services rendered through telemedicine.[177] Widespread use of telemedicine is expected to produce many benefits, including: increased access to health care services; greater efficiencies in care delivery; improved access to information; and reduced health care costs.[178] Recent studies suggest that in some cases, patient outcomes for certain services delivered through telemedicine in ambulatory settings appear to be comparable to services rendered in-person.[179, 180, 181] Existing fee-for-service models of care

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[166] MHCC, *Telemedicine Recommendations*, December 2011. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TLMD_Recommend_rpt_20111201.pdf.
[167] Md. Code Ann., Insurance § 15–139. See Appendix H.
[168] For more information on these laws, as well as others governing the practice of telemedicine in Maryland, see Appendix A, H-L.
[169] Md. Code Ann., Health - General § 19–319. See Appendix I.
[170] See Appendix K for proposed Maryland regulations to allow hospitals to use the credentialing of the distant site hospital for physicians that provide telemedicine services.
[171] Md. Code Ann., Health - General § 15–105.2. See Appendix J.
[172] See Appendix L for Maryland Medicaid Telemedicine Regulations.
[173] *Telemedicine Task Force – Maryland Health Care Commission*, Senate Bill 776 (Chapter 319) (2013 Regular Session). Available at Appendix A and: http://mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.
[174] MHCC, *Telemedicine Information Brief,* July 2013. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TLMD_Informa_brf_20130701.pdf. See Appendix M.
[175] MHCC *Health Information Technology: An Assessment of Maryland Hospitals*. September 2013. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit/documents/HIT_Hosp_HealthIT_Assess_MD_Rpt_20130901.pdf.
[176] Maryland Board of Physicians licensure data, 2011-2012
[177] Ibid n. 5.
[178] Journal of Telemedicine and Telecare, *Benefits and Drawbacks of Telemedicine*, 11(2) 2005.
[179] Journal of Pediatric Psychology, *Treating Rural Pediatric Obesity through Telemedicine: Outcomes from a Small Randomized Controlled Trial*, February 2013.

delivery and payment encourage episodic care delivery. Absent a transition to value-based service delivery and payment programs outlined in the ACA, there is little incentive for the medical community to adopt telemedicine.

2013 Task Force

In accordance with SB 776, MHCC reconvened the Task Force to identify opportunities to further expand the use of telemedicine to improve health status and care delivery in the State. The Task Force is also required to assess factors related to telehealth[182] and to identify strategies for telehealth deployment in rural areas of the State. Over the next year, MHCC will work with its three advisory groups to further analyze the topics in SB 776 and formulate recommendations.[183]

Clinical Advisory Group

The Clinical Advisory Group includes members from acute, ambulatory, post-acute, and home-based care, as well as representatives from State licensing boards and the medical society.[184] In the fall of 2013, the Clinical Advisory Group developed guiding principles (principles) to lead the work. Those principles center on the use of telemedicine to improve access to care and quality outcomes, boost health professional productivity, and support State and national initiatives to transform care delivery and reduce costs.[185]

Scope of Work

- The role of telemedicine in advanced primary care delivery models; innovative service models for diverse care settings;
- Use cases for evaluation (e.g., stroke, dermatology, emergency services, etc.);
- Patient engagement, education, and outcomes;
- Health professional productivity, resources, and shortages; and
- Underserved population areas.

Barriers Identified to Telemedicine Diffusion

- Lack of widespread awareness about how to incorporate the effective use of telemedicine into existing practice workflows;
- Limited advocacy for telemedicine within the provider community; and
- Perception of high up-front costs for telemedicine technology.

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[180] Journal of the American Medical Association Neurology, *Randomized Controlled Clinical Trial of 'Virtual House Calls' for Parkinson Disease*, March 2013.
[181] American Journal of Psychiatry, *Practice-Based Versus Telemedicine-Based Collaborative Care for Depression in Rural Federally Qualified Health Centers: A Pragmatic Randomized Comparative Effectiveness Trial*, April 2013.
[182] Telehealth includes non-clinical practices such as continuing medical education and nursing call centers (American Telemedicine Association). The use of telecommunication techniques for the purpose of proving telemedicine, medical education, and health education over a distance.
[183] See Appendix N for a table that identifies the topics for the Task Force outlined in SB 776, paired with the advisory group.
[184] See the Acknowledgements for a list of participants in the Clinical Advisory Group.
[185] See Appendix O for the guiding principles.

Key Areas of Deliberation

- Increasing awareness among practices about how telemedicine may be integrated into innovative care delivery models;
- Developing a telemedicine program for medical and ancillary school curricula and continuing medical education credits;
- Increasing access to care in underserved rural and rural areas, wherever access to care is limited;
- Developing a draft list of clinical use cases for telemedicine that have the potential to improve health outcomes while containing costs;
- Reviewing a national scan of other statewide telemedicine initiatives;[186]
- Establishing a lead entity to coordinate telemedicine efforts within the State; and
- Forming a sub-committee to further explore potential licensing and credentialing barriers to the adoption of telemedicine.

Policy Considerations

- Policy to guide the diffusion of telemedicine public health interventions and outcomes;
- Process measures to improve access to appropriate medical specialists; and
- Incorporation of evidence-based guidelines for services rendered through telemedicine.[187, 188]

The Clinical Advisory Group expects to identify telemedicine use cases that offer evidence-based outcomes and cost savings opportunities in 2014. This group also plans to evaluate requirements for continuing education programs to include telemedicine curricula. As part of its work, the Clinical Advisory Group will consider potential licensing barriers to telemedicine adoption and develop recommendations to mitigate these barriers.

Technology Solutions and Standards Advisory Group

The Technology Solutions and Standards Advisory Group is comprised of representatives from academic medical centers, community hospitals, county health departments, third party payors, vendors, providers, Maryland Medicaid, the Department of Health and Mental Hygiene, and the State-Designated health information exchange (HIE). This group developed guiding principles to direct the discussions, which focus on how telemedicine technology can be a vital component of innovative care delivery models.[189, 190]

Scope of Work

- Supportive uses of electronic health records (EHRs) and HIE;

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[186] MHCC, *Telemedicine Statewide Networks - Environmental Scan*, October 2013. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TLMD_Stwide_Network_Environ_Scan_20131001.pdf. See Appendix G.
[187] See Appendix P for National Telemedicine Standards and Guidelines.
[188] See Appendix Q for the American Telemedicine Association *Core Telemedicine Operational Standards.*
[189] See the Acknowledgements for a list of participants in the Technology Solutions and Standards Advisory Group.
[190] See Appendix O for the guiding principles.

- Emerging technology and standards for privacy and security; and
- Strategies for telehealth deployment in rural areas to increase access to health care.

Barriers Identified to Telemedicine Diffusion

- Availability of information about providers rendering telemedicine services;
- Integrating technology solutions with existing EHRs and HIEs; and
- Limited information about the availability of telemedicine service providers.

Key Areas of Deliberation

- The ability of ambulatory providers and hospitals to adopt technology solutions that best fit their needs;
- The development of a telemedicine provider registry (registry) that contains information on telemedicine providers, technology used, third party payor network, and availability to provide immediate consultative support. The registry is being conceptualized as follows:
    - A self-identified listing of telemedicine providers, including details about telemedicine capabilities;
    - Made available through the State-designated HIE query portal, which is a tool currently providing clinicians with access to clinical information from long-term care providers, laboratories, and radiology centers throughout Maryland; and
    - Implemented in a phased approach, allowing for enhancements over time:
        - *Phase 1 includes*: Provider information (name, practice location(s), specialty, insurance accepted, technology capabilities) and a resource center to provide educational information about telemedicine;
        - *Phase 2 includes*: Identifying providers currently available to deliver telemedicine services, and chat functionality for real-time communication;
        - *Phase 3 includes*: Consumer capabilities, integration with mobile devices, and features to attribute providers to practices and health systems in the registry.[191, 192]

Policy Considerations

- Use of the registry in emergent situations;
- Validation of information in the registry;
- Determination of standards to enable interoperability wherever patient records are stored; and
- Achieving compliance with federal and State privacy and security laws.

The Technology Solutions and Standards Advisory Group plans to finalize the technical specifications in 2014. This group will also address policy challenges of a registry, such as enabling

[191] The State-Designated HIE is the Chesapeake Regional Information System for our Patients (CRISP). More information is available at: http://crisphealth.org/.
[192] Providers must sign a participation agreement with CRISP and all users complete a credentialing and training process before being authorized to query the portal.

the inclusion of provider groups in addition to individual providers, and ensuring provider information is maintained and updated in a timely manner.

Finance and Business Model Advisory Group

The Finance and Business Model Advisory Group did not meet in 2013. It is comprised of representatives from academic medical centers, community hospitals, county health departments, payors, providers, Maryland Medicaid, and the Department of Health and Mental Hygiene. As the work of the Clinical Advisory Group and the Technology Solutions and Standards Advisory Group progress, the Finance and Business Model Advisory Group will convene to develop recommendations pertaining to advancing telemedicine in innovative care delivery models.

Scope of Work

- Applications for cost-effective telehealth;
- Innovative payment models;
- Public and private grant funding; and
- Strategies for telehealth deployment to meet increased demand for health care services due to implementation of the ACA.

Barriers Identified to Telemedicine Diffusion

- Traditional fee-for-service payment models incentivize volume-based care; providers are often fully scheduled with in-person visits and may not see the value of incorporating telemedicine into their existing practice workflows;
- Medicaid reimbursement for telemedicine services are limited to pilot programs; and
- Requirements for federal grant funding for telemedicine in rural areas are restrictive in Maryland, as Maryland's federally defined rural regions are geographically small when compared to other states that have higher telemedicine adoption rates.[193, 194, 195]

The Finance and Business Model Advisory Group will assess how telemedicine could be incorporated into the transformation of care delivery. This group will develop recommendations that stem from use cases and the technology under consideration by the Clinical Advisory Group and Technology Solutions and Standards Advisory Group.

Remarks

Telemedicine has the potential to improve access to health care services, enhance quality of care, and contain costs. In general, regulatory, reimbursement, and technology barriers limit the potential of telemedicine to meet these goals. Developing strategies to expand the diffusion and increase the use of telemedicine is a complex endeavor. Expanding adoption and increasing the use of telemedicine requires moving away from the way care is typically provided and embracing innovative approaches to care delivery. Over the next year, the Task Force will grapple with the difficult issues that must be addressed to ensure broad use of telemedicine in the future. The

[193] Ibid n. 8.
[194] See Appendix L for Maryland Medicaid Telemedicine Regulations.
[195] American Telemedicine Association, *State Telemedicine Legislation Tracking,* 2013. See Appendix D.

December 2014 report to the Governor and General Assembly will include recommendations supported by technology and a shift toward value-based delivery models.

End quoted text

Appendix E: Telehealth Defined across Federal Departments and Agencies

Federal agencies have varying definitions of *telehealth*. The table below outlines key commonalities and differences in how *telehealth* is defined across federal agencies. More information is available at: online.liebertpub.com/doi/pdf/10.1089/tmj.2013.0336. Commonalities and differences for the definition of *telemedicine* as currently defined in Maryland law and the definition for *telehealth* as proposed by the Telemedicine Task Force are also included in the table.

Commonalities and Differences in Definition of *Telehealth*						
		Health Care Services	**Education**	**Public Health**	**Health Administration**	**Rural/ Underserved**
U.S. Department of Agriculture		✓	✓			✓
U.S. Department of Commerce		✓	✓			
U.S. Department of Defense		✓	✓	✓	✓	
U.S. Department of Health and Human Services	Centers for Medicare and Medicaid Services	✓	✓			✓[196]
	Health Resources and Services Administration & National Institutes of Health	✓	✓	✓	✓	
	Indian Health Service	✓				✓
	Office of the National Coordinator for Health Information Technology	✓	✓		✓	
Federal Communications Commission		✓				
National Aeronautics and Space Administration		✓				✓
Veterans Administration		✓				
Maryland – current telemedicine definition		✓				✓
Maryland – proposed telehealth definition[197]		✓	✓	✓	✓	✓

[196] Coverage of Medicare telehealth services is limited by statute to services furnished to beneficiaries located in a rural area [see 42 USC x1395m(m)(4)(C)(i)].
[197] Unless excluded from reimbursement.

Appendix F: Md. Code Ann., Health - General §19–143

Begin quoted text

Md. HEALTH-GENERAL Code Ann. § 19-143

§ 19-143. Electronic health records

(a) Designation of health information exchange; grants. –

(1) On or before October 1, 2009, the Commission and the Health Services Cost Review Commission shall designate a health information exchange for the State.

(2) The Secretary, to align funding opportunities with the purposes of this section and the development and effective operation of the State's health information exchange, may provide grants to the health information exchange designated under paragraph (1) of this subsection.

(b) Progress report. -- On or before January 1, 2010, the Commission shall:

(1) Report, in accordance with § 2-1246 of the State Government Article, to the Senate Finance Committee and the House Health and Government Operations Committee on progress in implementing the requirements of subsections (a) and (d) of this section; and

(2) Include in the report recommendations for legislation specifying how incentives required for State-regulated payors that are national carriers shall take into account existing carrier activities that promote the adoption and meaningful use of electronic health records.

(c) Subsequent report for review and comment. –

(1) On or before January 1, 2011, following consultations with appropriate stakeholders, the Commission shall post on its website for public comment and submit to the Governor and, in accordance with § 2-1246 of the State Government Article, the Senate Finance Committee and the House Health and Government Operations Committee a report on:

(i) The development of a coordinated public-private approach to improve the State's health information infrastructure;

(ii) Any changes in State laws that are necessary to protect the privacy and security of health information stored in electronic health records or exchanged through a health information exchange in the State;

(iii) Any changes in State laws that are necessary to provide for the effective operation of a health information exchange;

(iv) Any actions that are necessary to align funding opportunities under the federal American Recovery and Reinvestment Act of 2009 with other State and private sector initiatives related to health information technology, including:

1. The patient-centered medical home;

2. The electronic health record demonstration project supported by the federal Centers for Medicare and Medicaid Services;

3. The health information exchange; and

4. The Medicaid Information Technology Architecture Initiative; and

(v) Recommended language for the regulations required under subsection (d) of this section.

(2) The Senate Finance Committee and the House Health and Government Operations Committee shall have 60 days from receipt of the report for review and comment.

(d) Regulations; legislative intent. –

(1) On or before September 1, 2011, the Commission, in consultation with the Department, payors, and health care providers, shall adopt regulations that require State-regulated payors to provide incentives to health care providers to promote the adoption and meaningful use of electronic health records.

(2) Incentives required under the regulations:

(i) Shall have monetary value;

(ii) Shall facilitate the use of electronic health records by health care providers in the State;

(iii) To the extent feasible, shall recognize and be consistent with existing payor incentives that promote the adoption and meaningful use of electronic health records;

(iv) Shall take into account:

1. Incentives provided to health care providers under Medicare and Medicaid; and

2. Any grants or loans that are available to health care providers from the federal government;

(v) May include:

1. Increased reimbursement for specific services;

2. Lump sum payments;

3. Gain-sharing arrangements;

4. Rewards for quality and efficiency;

5. In-kind payments; and

6. Other items or services to which a specific monetary value can be assigned; and

(vi) Shall be paid in cash, unless the State-regulated payor and the health care provider agree on an incentive of equivalent value.

(3) The regulations need not require incentives for the adoption and meaningful use of electronic health records for each type of health care provider listed in § 19-142(e) of this subtitle.

(4) If federal law is amended to allow the State to regulate payments made by entities that self-insure their health benefit plans, regulations adopted under this section shall apply to those entities to the same extent to which they apply to State-regulated payors.

(5) Regulations adopted under this subsection:

(i) May not require a group model health maintenance organization, as defined in § 19-713.6 of this title, to provide an incentive to a health care provider who is employed by the multispecialty group of physicians under contract with the group model health maintenance organization; and

(ii) Shall allow a State-regulated payor to:

1. Request information from a health care provider to validate the health care provider's incentive claim; and

2. If the State-regulated payor determines that a duplicate incentive payment or an overpayment has been made, reduce the incentive amount.

(6) The Commission may:

(i) Audit the State-regulated payor or the health care provider for compliance with the regulations adopted under this subsection; and

(ii) If it finds noncompliance, request corrective action.

(7) It is the intent of the General Assembly that the State Employee and Retiree Health and Welfare Benefits Program support the incentives provided under this subsection through contracts between the Program and the third party administrators arranging for the delivery of health care services to members covered under the Program.

(e) Actions to ensure compliance with federal law. -- The Health Services Cost Review Commission, in consultation with hospitals, payors, and the federal Centers for Medicare and Medicaid Services, shall take the actions necessary to:

(1) Assure that hospitals in the State receive the payments provided under § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations; and

(2) Implement any changes in hospital rates required by the federal Centers for Medicare and Medicaid Services to ensure compliance with § 4102 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(f) Mechanism for receipt of payments for participants in State medical assistance program. -- The Department, in consultation with the Commission, shall develop a mechanism to assure that health care providers that participate in the Maryland Medical Assistance Program receive the payments provided for adoption and use of electronic health records technology under § 4201 of the federal American Recovery and Reinvestment Act of 2009 and any subsequent federal rules and regulations.

(g) Report to Governor and General Assembly. -- On or before October 1, 2012, the Commission shall report to the Governor and, in accordance with § 2-1246 of the State Government Article, the General Assembly on progress achieved toward adoption and meaningful use of electronic health

records by health care providers in the State and recommendations for any changes in State laws that may be necessary to achieve optimal adoption and use.

(h) Designation of management service organization. –

(1) On or before October 1, 2012, the Commission shall designate one or more management service organizations to offer services throughout the State.

(2) The Commission may use federal grants and loans to help subsidize the use of the designated management service organizations by health care providers.

(i) Requirements of electronic health records. -- On and after the later of January 1, 2015, or the date established for the imposition of penalties under § 4102 of the federal American Recovery and Reinvestment Act of 2009:

(1) Each health care provider using an electronic health record that seeks payment from a State-regulated payor shall use electronic health records that are:

(i) Certified by a national certification organization designated by the Commission; and

(ii) Capable of connecting to and exchanging data with the health information exchange designated by the Commission under subsection (a) of this section; and

(2) The incentives required under subsection (d) of this section may include reductions in payments to a health care provider that does not use electronic health records that meet the requirements of paragraph (1) of this subsection.

HISTORY: 2009, ch. 689; 2011, chs. 380, 532, 533; 2013, ch. 159, § 2; 2014, ch. 45.

End quoted text

Appendix G: Md. Code Ann., Health-General § 19-1A-01

Begin quoted text

Md. HEALTH-GENERAL Code Ann. § 19-1A-01

§ 19-1A-01. Definitions [subtitle subject to abrogation]

(a) In general. -- In this subtitle the following words have the meanings indicated.

(b) Carrier. -- "Carrier" has the meaning stated in *§ 15-1801 of the Insurance Article.*

(c) Federally qualified health center. -- "Federally qualified health center" has the meaning stated in *42 U.S.C. § 254b.*

(d) Health benefit plan. -- "Health benefit plan" has the meaning stated in *§ 15-1801 of the Insurance Article.*

(e) Managed care organization. -- "Managed care organization" has the meaning stated in § 15-101 of this article.

(f) Patient centered medical home. -- "Patient centered medical home" means a primary care practice organized to provide a first, coordinated, ongoing, and comprehensive source of care to patients to:

(1) Foster a partnership with a qualifying individual;

(2) Coordinate health care services for a qualifying individual; and

(3) Exchange medical information with carriers, other providers, and qualifying individuals.

(g) Primary care practice. -- "Primary care practice" means a practice or federally qualified health center organized by or including pediatricians, general internal medicine physicians, family medicine physicians, or nurse practitioners.

(h) Prominent carrier. --

(1) "Prominent carrier" means a carrier reporting at least $ 90,000,000 in written premiums for health benefit plans in the State in the most recent Maryland health benefit plan report submitted to the Insurance Commissioner as required under *§ 15-605 of the Insurance Article.*

(2) "Prominent carrier" does not include a group model health maintenance organization as defined in § 19-713.6 of this title.

(i) Qualifying individual. -- "Qualifying individual" means:

(1) A person covered under a health benefit plan issued by a carrier; or

(2) A member of a managed care organization.

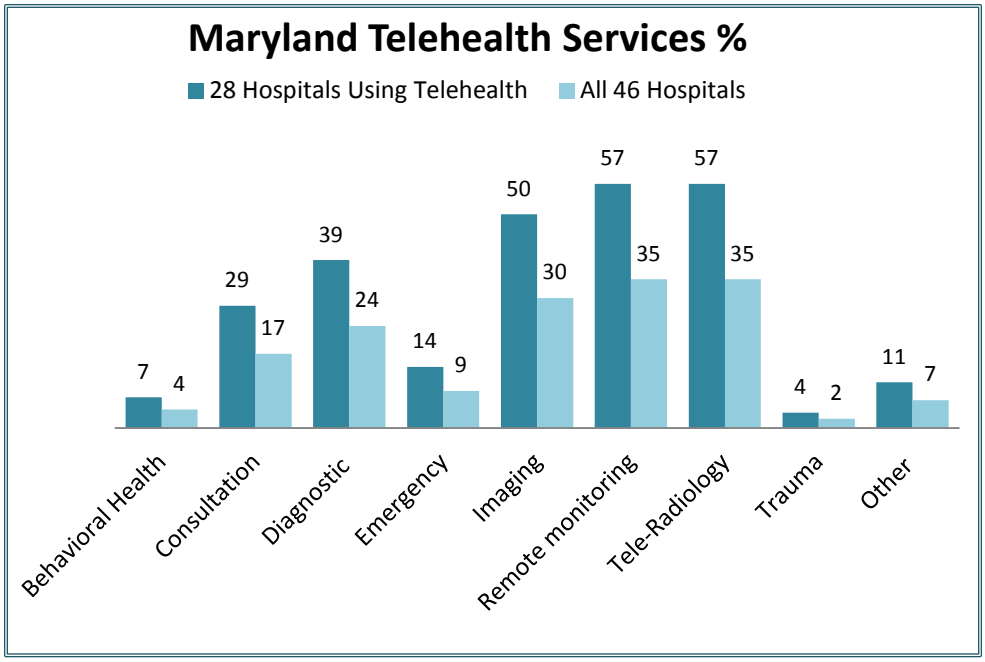
(j) Single carrier patient centered medical home program. -- "Single carrier patient centered medical home program" has the meaning stated in *§ 15-1801 of the Insurance Article.*

HISTORY: 2010, chs. 5, 6

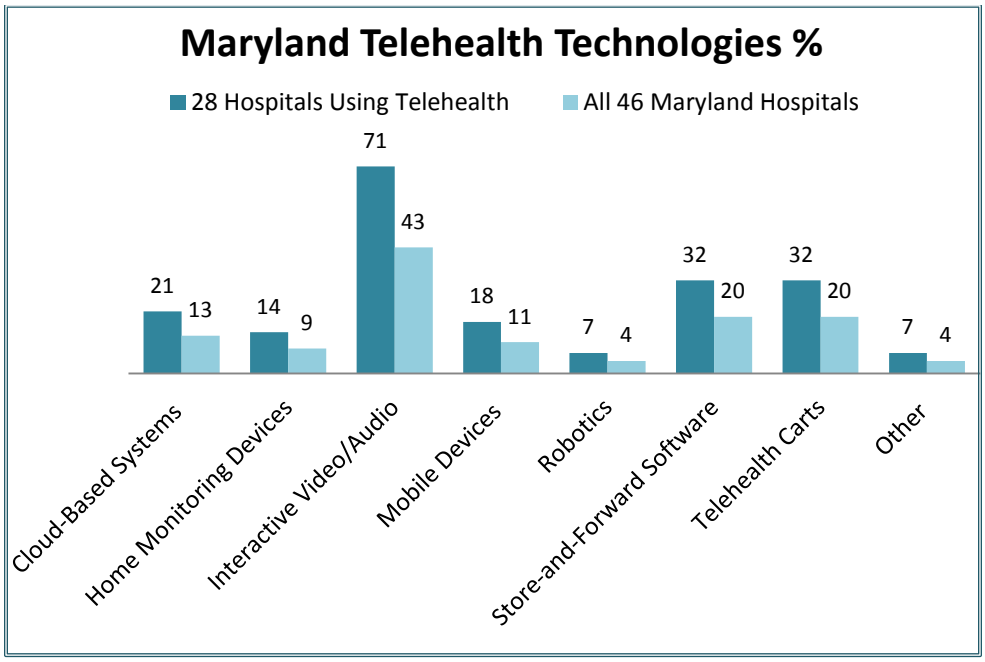
End quoted text

Appendix H: Telehealth Adoption among General Acute Care Hospitals

Approximately 61 percent of general acute care hospitals in Maryland reported using telehealth in 2013. The following graphs show the types of telehealth services provided by hospitals and the types of technology used.[198]



Note: Other includes services rendered in a hospital's Intensive Care Unit.



Note: Other technologies include intra-operative neuro-physiological monitors or electronic ICU program software that assists with physician or nurse shortages.

[198] MHCC, *Health Information Technology: An Assessment of Maryland Hospitals*, 2013.

Telehealth Services by General Acute Hospitals

Hospital n=28	Diffusion of Telehealth Services within Hospital Departments									
	Behavioral Health		Consultation		Diagnostic		Emergency		Imaging	
	Departments									
	#	%	#	%	#	%	#	%	#	%
Anne Arundel Medical Center	-	-	2	5	2	5	-	-	-	-
Atlantic General Hospital	-	-	-	-	-	-	-	-	1	17
Bon Secours Baltimore Health System	-	-	1	9	1	9	-	-	-	-
Calvert Memorial Hospital	-	-	-	-	1	4	1	4	1	4
Carroll County General Hospital	-	-	1	7	-	-	1	7	1	7
Doctors Community Hospital	1	4	-	-	-	-	-	-	-	-
Fort Washington Hospital	-	-	-	-	1	2	-	-	1	2
Frederick Memorial Hospital	-	-	1	2	1	2	-	-	1	2
Holy Cross Hospital	-	-	2	6	-	-	-	-	-	-
Howard County General Hospital	-	-	-	-	-	-	-	-	1	3
Johns Hopkins Hospital	-	-	3	4	6	8	-	-	6	8
MedStar Franklin Square Medical Center	-	-	1	2	-	-	-	-	1	2
MedStar Good Samaritan Hospital	-	-	-	-	-	-	-	-	1	1
MedStar Montgomery Medical Center	-	-	-	-	-	-	1	7	-	-
MedStar Southern Maryland Hospital	-	-	-	-	1	4	-	-	-	-
MedStar St. Mary's Hospital	-	-	-	-	1	6	-	-	-	-
Mercy Medical Center	-	-	-	-	1	6	-	-	1	6
Merits Medical Center	-	-	-	-	-	-	-	-	1	3
Peninsula Regional Medical Center	1	4	4	17	2	9	1	4	4	17
Shady Grove Adventist Hospital	-	-	-	-	-	-	-	-	-	-
Suburban Hospital	-	-	-	-	-	-	-	-	-	-
Union Hospital of Cecil County	-	-	-	-	1	3	-	-	1	3
University of Maryland Baltimore Washington Medical Center	-	-	-	-	-	-	-	-	1	3
University of Maryland Medical Center	-	-	-	-	-	-	-	-	-	-
University of Maryland Shore Medical Center at Chestertown	-	-	-	-	-	-	-	-	-	-
University of Maryland Shore Medical Center at Dorchester	-	-	-	-	-	-	-	-	-	-
University of Maryland Shore Medical Center at Easton	-	-	-	-	-	-	-	-	-	-
Washington Adventist Hospital	-	-	-	-	-	-	-	-	-	-

(Continued)

Hospital n=28	Diffusion of Telehealth Services within Hospital Departments							
	Remote Monitoring		Tele-radiology		Trauma		Other	
	Departments							
	#	%	#	%	#	%	#	%
Anne Arundel Medical Center	-	-	-	-	-	-	-	-
Atlantic General Hospital	1	17	-	-	-	-	-	-
Bon Secours Baltimore Health System	1	9	-	-	-	-	-	-
Calvert Memorial Hospital	1	4	1	4	-	-	1	4
Carroll County General Hospital	1	7	1	7	-	-	-	-
Doctors Community Hospital	-	-	-	-	-	-	-	-
Fort Washington Hospital	-	-	1	2	-	-	1	2
Frederick Memorial Hospital	1	2	1	2	-	-	1	2
Holy Cross Hospital	-	-	-	-	-	-	-	-
Howard County General Hospital	-	-	1	3	-	-	-	-
Johns Hopkins Hospital	-	-	-	-	-	-	-	-
MedStar Franklin Square Medical Center	-	-	1	2	-	-	-	-
MedStar Good Samaritan Hospital	1	1	-	-	-	-	-	-
MedStar Montgomery Medical Center	-	-	1	7	-	-	-	-
MedStar Southern Maryland Hospital	1	4	-	-	-	-	-	-
MedStar St. Mary's Hospital	1	6	14	88	-	-	-	-
Mercy Medical Center	-	-	1	6	-	-	-	-
Merits Medical Center	1	3	1	3	1	3	-	-
Peninsula Regional Medical Center	1	4	2	9	-	-	-	-
Shady Grove Adventist Hospital	1	3	1	3	-	-	-	-
Suburban Hospital	-	-	1	7	-	-	-	-
Union Hospital of Cecil County	1	3	1	3	-	-	-	-
University of Maryland Baltimore Washington Medical Center	-	-	1	3	-	-	-	-
University of Maryland Medical Center	10	13	-	-	-	-	-	-
University of Maryland Shore Medical Center at Chestertown	1	10	-	-	-	-	-	-
University of Maryland Shore Medical Center at Dorchester	1	11	-	-	-	-	-	-
University of Maryland Shore Medical Center at Easton	1	5	-	-	-	-	-	-
Washington Adventist Hospital	1	6	1	6	-	-	-	-

Note: Other services may include services rendered in a hospital's Intensive Care Unit.

Telehealth Technologies by General Acute Hospitals

Hospital n=28	Diffusion of Telehealth Technologies Within Hospital Departments							
	Interactive Video/ Audio		Store-and Forward Software		Robotics		Home Monitoring Devices	
	Departments							
	#	%	#	%	#	%	#	%
Anne Arundel Medical Center	2	5	-	-	-	-	-	-
Atlantic General Hospital	1	17	1	17	-	-	-	-
Bon Secours Baltimore Health System	1	9	1	9	1	9	-	-
Calvert Memorial Hospital	2	8	2	8	-	-	-	-
Carroll County General Hospital	1	7	1	7	-	-	1	7
Doctors Community Hospital	-	-	-	-	-	-	-	-
Fort Washington Hospital	1	2	3	5	-	-	-	-
Frederick Memorial Hospital	1	2	1	2	1	2	1	2
Holy Cross Hospital	2	6	-	-	-	-	-	-
Howard County General Hospital	2	5	-	-	-	-	-	-
Johns Hopkins Hospital	-	-	6	8	-	-	-	-
MedStar Franklin Square Medical Center	1	2	-	-	-	-	-	-
MedStar Good Samaritan Hospital	-	-	-	-	-	-	-	-
MedStar Montgomery Medical Center	1	7	-	-	-	-	-	-
MedStar Southern Maryland Hospital	1	4	-	-	-	-	-	-
MedStar St. Mary's Hospital	1	6	-	-	-	-	-	-
Mercy Medical Center	-	-	1	6	-	-	-	-
Merits Medical Center	1	3	-	-	-	-	-	-
Peninsula Regional Medical Center	4	17	-	-	-	-	-	-
Shady Grove Adventist Hospital	-	-	-	-	-	-	1	3
Suburban Hospital	-	-	-	-	-	-	-	-
Union Hospital of Cecil County	1	3	1	3	-	-	-	-
University of Maryland Baltimore Washington Medical Center	-	-	-	-	-	-	-	-
University of Maryland Medical Center	10	13	-	-	-	-	-	-
University of Maryland Shore Medical Center at Chestertown	1	10	-	-	-	-	-	-
University of Maryland Shore Medical Center at Dorchester	1	11	-	-	-	-	-	-
University of Maryland Shore Medical Center at Easton	1	5	-	-	-	-	-	-
Washington Adventist Hospital	-	-	-	-	-	-	1	6

(Continued)

Hospital n=28	Diffusion of Telehealth Technologies Within Hospital Departments							
	Telehealth Carts		Mobile Devices[199]		Cloud-Based Systems[200]		Other	
	Departments							
	#	%	#	%	#	%	#	%
Anne Arundel Medical Center	-	-	-	-	-	-	-	-
Atlantic General Hospital	-	-	-	-	-	-	-	-
Bon Secours Baltimore Health System	-	-	-	-	-	-	-	-
Calvert Memorial Hospital	-	-	-	-	-	-	1	4
Carroll County General Hospital	-	-	1	7	-	-	-	-
Doctors Community Hospital	1	4	-	-	-	-	-	-
Fort Washington Hospital	-	-	-	-	-	-	-	-
Frederick Memorial Hospital	1	2	-	-	1	2	-	-
Holy Cross Hospital	4	13	-	-	-	-	-	-
Howard County General Hospital	1	3	-	-	-	-	-	-
Johns Hopkins Hospital	-	-	-	-	-	-	-	-
MedStar Franklin Square Medical Center	-	-	-	-	1	2	-	-
MedStar Good Samaritan Hospital	-	-	-	-	-	-	2	2
MedStar Montgomery Medical Center	1	7	-	-	-	-		
MedStar Southern Maryland Hospital	-	-	-	-	-	-	-	-
MedStar St. Mary's Hospital	1	6	-	-	-	-	-	-
Mercy Medical Center	-	-	-	-	-	-	-	-
Merits Medical Center	1	3	-	-	1	3	-	-
Peninsula Regional Medical Center	4	17	3	13	2	9	-	-
Shady Grove Adventist Hospital	-	-	1	3	1	3	-	-
Suburban Hospital	-	-	-	-	1	7	-	-
Union Hospital of Cecil County	-	-	1	3	-	-	-	-
University of Maryland Baltimore Washington Medical Center	-	-	-	-	-	-	-	-
University of Maryland Medical Center	-	-	-	-	-	-	-	-
University of Maryland Shore Medical Center at Chestertown	-	-	-	-	-	-	-	-
University of Maryland Shore Medical Center at Dorchester	-	-	-	-	-	-	-	-
University of Maryland Shore Medical Center at Easton	-	-	-	-	-	-	-	-
Washington Adventist Hospital	-	-	1	6	1	6	-	-

Note: Other technologies may include intra-operative neuro-physiological monitors or electronic ICU program software that assist with physician or nurse shortages.

[199] Mobile devices include iPads, tablets, etc.
[200] Cloud-based systems are used for services such as remote monitoring or image review/distribution.

Appendix I: Md. Code Ann., Insurance § 15–139

Begin quoted text

Md. INSURANCE Code Ann. § 15-139

§ 15-139. Coverage for services delivered through telemedicine

(a) "Telemedicine" defined. --

(1) In this section, "telemedicine" means, as it relates to the delivery of health care services, the use of interactive audio, video, or other telecommunications or electronic technology by a licensed health care provider to deliver a health care service within the scope of practice of the health care provider at a site other than the site at which the patient is located.

(2) "Telemedicine" does not include:

(i) an audio-only telephone conversation between a health care provider and a patient;

(ii) an electronic mail message between a health care provider and a patient; or

(iii) a facsimile transmission between a health care provider and a patient.

(b) Applicability. -- This section applies to:

(1) insurers and nonprofit health service plans that provide hospital, medical, or surgical benefits to individuals or groups on an expense-incurred basis under health insurance policies or contracts that are issued or delivered in the State; and

(2) health maintenance organizations that provide hospital, medical, or surgical benefits to individuals or groups under contracts that are issued or delivered in the State.

(c) Coverage. -- An entity subject to this section:

(1) shall provide coverage under a health insurance policy or contract for health care services appropriately delivered through telemedicine; and

(2) may not exclude from coverage a health care service solely because it is provided through telemedicine and is not provided through an in-person consultation or contact between a health care provider and a patient.

(d) Reimbursement and deductible. -- An entity subject to this section:

(1) shall reimburse a health care provider for the diagnosis, consultation, and treatment of an insured patient for a health care service covered under a health insurance policy or contract that can be appropriately provided through telemedicine;

(2) is not required to:

(i) reimburse a health care provider for a health care service delivered in person or through telemedicine that is not a covered benefit under the health insurance policy or contract; or

(ii) reimburse a health care provider who is not a covered provider under the health insurance policy or contract; and

(3) (i) may impose a deductible, copayment, or coinsurance amount on benefits for health care services that are delivered either through an in-person consultation or through telemedicine;

(ii) may impose an annual dollar maximum as permitted by federal law; and

(iii) may not impose a lifetime dollar maximum.

(e) Utilization review. -- An entity subject to this section may undertake utilization review, including preauthorization, to determine the appropriateness of any health care service whether the service is delivered through an in-person consultation or through telemedicine if the appropriateness of the health care service is determined in the same manner.

(f) Discrimination prohibited. -- A health insurance policy or contract may not distinguish between patients in rural or urban locations in providing coverage under the policy or contract for health care services delivered through telemedicine.

(g) Adverse decision. -- A decision by an entity subject to this section not to provide coverage for telemedicine in accordance with this section constitutes an adverse decision, as defined in § 15-10A-01 of this title, if the decision is based on a finding that telemedicine is not medically necessary, appropriate, or efficient.

HISTORY: 2012, chs. 579, 580; 2013, ch. 280.

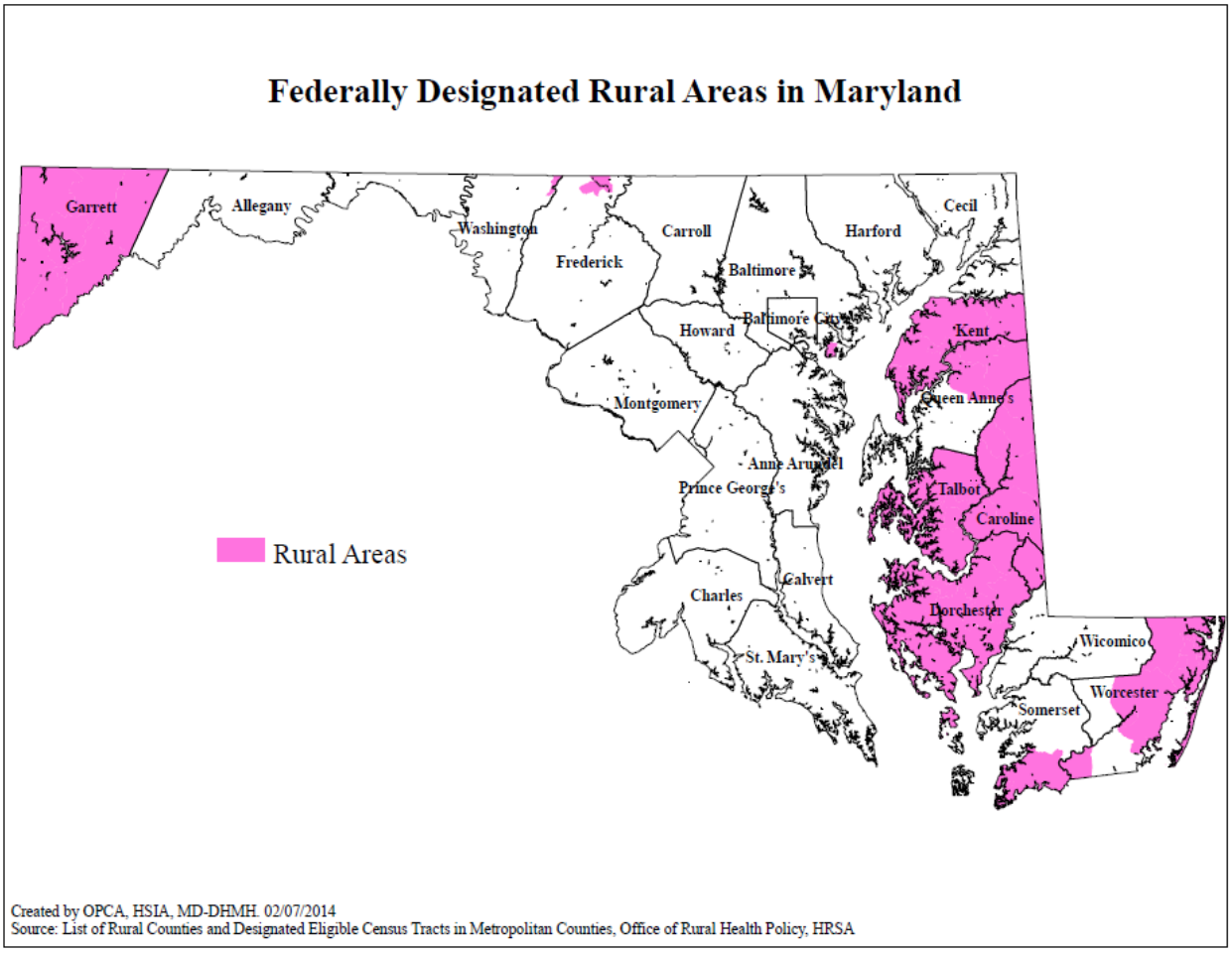
NOTES: EDITOR'S NOTE. --Section 4, chs. 579 and 580, Acts 2012, provides that "this Act shall apply to all policies, contracts, and health benefit plans issued, delivered, or renewed in the State on or after October 1, 2012."

Section 5, chs. 579 and 580, Acts 2012, provides that the acts shall take effect October 1, 2012. EFFECT OF AMENDMENTS. --Chapter 280, Acts 2013, effective October 1, 2013, reenacted (a) without change.

End quoted text

Appendix J: Map of Federally Designated Rural Areas in Maryland

The following map provides an illustration of the federally designated rural areas in Maryland. Sixty-three census tracts, or roughly 4.5 percent, out of 1,406 total census tracts in Maryland, are federally designated rural. Additional information is available from the State Office of Rural Health at: hsia.dhmh.maryland.gov/opca/SitePages/publications.aspx#SORH.



Appendix K: Reimbursable Medicare Telemedicine Services

The Centers for Medicare & Medicaid Services released a fact sheet on telehealth reimbursable services in the Medicare Fee-for-Service program. The fact sheet is available online at: www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/telehealthsrvcsfctsht.pdf.

Begin quoted text

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Medicare Learning Network®
Official Information Health Care Professionals Can Trust

Telehealth Services

RURAL HEALTH FACT SHEET SERIES

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

This publication provides the following information on calendar year (CY) 2014 Medicare telehealth services:

- Originating sites;
- Distant site practitioners;
- Telehealth services;
- Billing and payment for professional services furnished via telehealth;
- Billing and payment for the originating site facility fee;
- Resources; and
- Lists of helpful websites and Regional Office Rural Health Coordinators.

When "you" is used in this publication, we are referring to physicians or practitioners at the distant site.

Medicare pays for a limited number of Part B services furnished by a physician or practitioner to an eligible beneficiary via a telecommunications system. For eligible telehealth services, the use of a telecommunications system substitutes for an in-person encounter.

ORIGINATING SITES

An originating site is the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in:

- A rural Health Professional Shortage Area, either located outside of a Metropolitan Statistical Area (MSA) or in a rural census tract, as determined by the Office of Rural Health Policy within the Health Resources and Services Administration (HRSA); or
- A county outside of a MSA.

ICN 901705 April 2014

You can access HRSA's website tool to determine a potential originating site's eligibility for Medicare telehealth payment at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the Centers for Medicare & Medicaid Services (CMS) website.

Entities that participate in a Federal telemedicine demonstration project approved by (or receiving funding from) the Secretary of the Department of Health and Human Services as of December 31, 2000, qualify as originating sites regardless of geographic location.

Each CY, the geographic eligibility of an originating site is established, based on the status of the area as of December 31st of the prior calendar year, and such eligibility continues for the full CY.

The originating sites authorized by law are:

- The offices of physicians or practitioners;
- Hospitals;
- Critical Access Hospitals (CAH);
- Rural Health Clinics;
- Federally Qualified Health Centers;
- Hospital-based or CAH-based Renal Dialysis Centers (including satellites);
- Skilled Nursing Facilities (SNF); and
- Community Mental Health Centers (CMHC).

Note: Independent Renal Dialysis Facilities are not eligible originating sites.

DISTANT SITE PRACTITIONERS

Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:

- Physicians;
- Nurse practitioners (NP);
- Physician assistants (PA);
- Nurse-midwives;
- Clinical nurse specialists (CNS);
- Clinical psychologists (CP) and clinical social workers (CSW). CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838; and
- Registered dietitians or nutrition professionals.

TELEHEALTH SERVICES

As a condition of payment, an interactive audio and video telecommunications system must be used that permits real-time communication between you, at the distant site, and the beneficiary, at the originating site. Asynchronous "store and forward" technology is permitted only in Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

The chart on page 3 provides the CY 2014 list of Medicare telehealth services.

CY 2014 Medicare Telehealth Services

Service	Healthcare Common Procedure Coding System (HCPCS)/CPT Code
Telehealth consultations, emergency department or initial inpatient	HCPCS codes G0425 – G0427
Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs	HCPCS codes G0406 – G0408
Office or other outpatient visits	CPT codes 99201 – 99215
Subsequent hospital care services, with the limitation of 1 telehealth visit every 3 days	CPT codes 99231 – 99233
Subsequent nursing facility care services, with the limitation of 1 telehealth visit every 30 days	CPT codes 99307 – 99310
Individual and group kidney disease education services	HCPCS codes G0420 and G0421
Individual and group diabetes self-management training services, with a minimum of 1 hour of in-person instruction to be furnished in the initial year training period to ensure effective injection training	HCPCS codes G0108 and G0109
Individual and group health and behavior assessment and intervention	CPT codes 96150 – 96154
Individual psychotherapy	CPT codes 90832 – 90834 and 90836 – 90838
Telehealth Pharmacologic Management	HCPCS code G0459
Psychiatric diagnostic interview examination	CPT codes 90791 and 90792
End-Stage Renal Disease (ESRD)-related services included in the monthly capitation payment	CPT codes 90951, 90952, 90954, 90955, 90957, 90958, 90960, and 90961
Individual and group medical nutrition therapy	HCPCS code G0270 and CPT codes 97802 – 97804
Neurobehavioral status examination	CPT code 96116
Smoking cessation services	HCPCS codes G0436 and G0437 and CPT codes 99406 and 99407
Alcohol and/or substance (other than tobacco) abuse structured assessment and intervention services	HCPCS codes G0396 and G0397
Annual alcohol misuse screening, 15 minutes	HCPCS code G0442
Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes	HCPCS code G0443
Annual depression screening, 15 minutes	HCPCS code G0444
High-intensity behavioral counseling to prevent sexually transmitted infection; face-to-face, individual, includes: education, skills training and guidance on how to change sexual behavior; performed semi-annually, 30 minutes	HCPCS code G0445
Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes	HCPCS code G0446
Face-to-face behavioral counseling for obesity, 15 minutes	HCPCS code G0447
Transitional care management services with moderate medical decision complexity (face-to-face visit within 14 days of discharge) (effective for services furnished on and after January 1, 2014)	CPT code 99495
Transitional care management services with high medical decision complexity (face-to-face visit within 7 days of discharge) (effective for services furnished on and after January 1, 2014)	CPT code 99496

For ESRD-related services, at least one "hands on" visit (not telehealth) must be furnished each month to examine the vascular access site by a physician, NP, PA, or CNS.

BILLING AND PAYMENT FOR PROFESSIONAL SERVICES FURNISHED VIA TELEHEALTH

You should submit claims for telehealth services using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GT, "via interactive audio and video telecommunications systems" (for example, 99201 GT). By coding and billing the GT modifier with a covered telehealth procedure code, you are certifying that the beneficiary was present at an eligible originating site when the telehealth service was furnished. By coding and billing the GT modifier with a covered ESRD-related service telehealth code, you are certifying that one visit per month was furnished "hands on" to examine the vascular access site.

For Federal telemedicine demonstration programs conducted in Alaska or Hawaii, you should submit claims using the appropriate CPT or HCPCS code for the professional service along with the telehealth modifier GQ if telehealth services were performed "via an asynchronous telecommunications system" (for example, 99201 GQ). By using the GQ modifier, you are certifying that the asynchronous medical file was collected and transmitted to you at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii.

You should bill the Medicare Administrative Contractor (MAC) for covered telehealth services. Medicare pays you the appropriate amount under the Medicare Physician Fee Schedule (PFS) for telehealth services. When you are located in a CAH and have reassigned your billing rights to a CAH that has elected the Optional Payment Method, the CAH bills the MAC for telehealth services and the payment amount is 80 percent of the Medicare PFS for telehealth services.

BILLING AND PAYMENT FOR THE ORIGINATING SITE FACILITY FEE

Originating sites are paid an originating site facility fee for telehealth services as described by HCPCS code Q3014. You should bill the MAC for the originating site facility fee, which is a separately billable Part B payment.

Note: When a CMHC serves as an originating site, the originating site facility fee does not count toward the number of services used to determine payment for partial hospitalization services.

RESOURCES

The chart below provides telehealth services resource information.

Telehealth Services Resources

For More Information About...	Resource
Telehealth Services	http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth on the CMS website Chapter 15 of the "Medicare Benefit Policy Manual" (Publication 100-02) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf on the CMS website Chapter 12 of the "Medicare Claims Processing Manual" (Publication 100-04) located at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf on the CMS website
Health Professional Shortage Areas	Medicare Learning Network® (MLN) publication titled "Health Professional Shortage Area (HPSA) Physician Bonus, HPSA Surgical Incentive Payment, and Primary Care Incentive Payment Programs" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HPSAfctsht.pdf on the CMS website
Office of Rural Health Policy within Health Resources and Services Administration	http://www.hrsa.gov/ruralhealth on the HRSA website
All Available MLN Products	"Medicare Learning Network® Catalog of Products" located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MLNCatalog.pdf on the CMS website or scan the Quick Response (QR) code on the right
Provider-Specific Medicare Information	MLN publication titled "MLN Guided Pathways: Provider Specific Medicare Resources" booklet located at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/Guided_Pathways_Provider_Specific_Booklet.pdf on the CMS website
Medicare Information for Beneficiaries	http://www.medicare.gov on the CMS website

HELPFUL WEBSITES

American Hospital Association Rural Health Care
http://www.aha.org/advocacy-issues/rural

Critical Access Hospitals Center
http://www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html

Disproportionate Share Hospital
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html

Federally Qualified Health Centers Center
http://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-FQHC-Center.html

Health Resources and Services Administration
http://www.hrsa.gov

Hospital Center
http://www.cms.gov/Center/Provider-Type/Hospital-Center.html

Medicare Learning Network®
http://go.cms.gov/MLNGenInfo

National Association of Community Health Centers
http://www.nachc.org

National Association of Rural Health Clinics
http://narhc.org

National Rural Health Association
http://www.ruralhealthweb.org

Physician Bonuses
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HPSAPSAPhysicianBonuses

Rural Assistance Center
http://www.raconline.org

Rural Health Clinics Center
http://www.cms.gov/Center/Provider-Type/Rural-Health-Clinics-Center.html

Swing Bed Providers
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Telehealth
http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth

U.S. Census Bureau
http://www.census.gov

REGIONAL OFFICE RURAL HEALTH COORDINATORS

Below is a list of contact information for CMS Regional Office Rural Health Coordinators who provide technical, policy, and operational assistance on rural health issues.

Region I – Boston
Rick Hoover
Email: rick.hoover@cms.hhs.gov
Telephone: (617) 565-1258
States: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Region II – New York
Miechal Lefkowitz
Email: miechal.lefkowitz@cms.hhs.gov
Telephone: (212) 616-2517
States: New Jersey, New York, Puerto Rico, and Virgin Islands

Region III – Philadelphia
Patrick Hamilton
Email: patrick.hamilton@cms.hhs.gov
Telephone: (215) 861-4097
States: Delaware, Maryland, Pennsylvania, Virginia, West Virginia, and the District of Columbia

Region IV – Atlanta
Lana Dennis
Email: lana.dennis@cms.hhs.gov
Telephone: (404) 562-7379
States: Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, and Tennessee

Region V – Chicago
Nicole Jacobson
Email: nicole.jacobson@cms.hhs.gov
Telephone: (312) 353-5737
States: Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

Region VI – Dallas
Kaleigh Emerson
Email: kaleigh.emerson@cms.hhs.gov
Telephone: (214) 767-6444
States: Arkansas, Louisiana, New Mexico, Oklahoma, and Texas

Region VII – Kansas City
Claudia Odgers
Email: claudia.odgers@cms.hhs.gov
Telephone: (816) 426-6524
States: Iowa, Kansas, Missouri, and Nebraska

Region VIII – Denver
Lyla Nichols
Email: lyla.nichols@cms.hhs.gov
Telephone: (303) 844-6218
States: Colorado, Montana, North Dakota, South Dakota, Utah, and Wyoming

Region IX – San Francisco
Neal Logue
Email: neal.logue@cms.hhs.gov
Telephone: (415) 744-3551
States: Arizona, California, Hawaii, Nevada, Guam, Commonwealth of the Northern Mariana Islands, and American Samoa

Region X – Seattle
Teresa Cumpton
Email: teresa.cumpton@cms.hhs.gov
Telephone: (206) 615-2391
States: Alaska, Idaho, Oregon, and Washington

Appendix L: Proposed Amendments to COMAR 10.09.49

Begin quoted text

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

10.09.49 Telemedicine Services

Authority: Health-General Article, §2-104(b), Annotated Code of Maryland; Ch. 280, Acts of 2013

Notice of Proposed Action

[14-283-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulations **.01—.07**, **.11**, and **.12** under **COMAR 10.09.49 Telemedicine Services**.

Statement of Purpose

The purpose of this action is to repeal the geographic limitations on healthcare services delivered via telemedicine. This amendment is in accordance with Chs. 141 and 426, Acts of 2014.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The Department will reimburse eligible physicians and hospitals for providing health services via telemedicine. For the expansion of telemedicine services, the increase in total Medicaid expenditures is predicted to be approximately $12,660 (total funds). Costs may be offset by savings in the outpatient category from fewer ER visits and follow-up visits to specialists.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	(E-)	$12,660
B. On other State agencies:	NONE	
C. On local governments:	NONE	

	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(+)	$12,660
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	NONE	

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

A. and D. The Department analyzed the number of telemedicine claims processed by CareFirst Blue Cross Blue Shield in CY 2011. CareFirst is the largest commercial payer in the State of Maryland and the Department assumes that the adoption rate of telemedicine by Medicaid providers will be similar to what CareFirst has experienced.

In CY 2011, CareFirst had a total of 2.1 million members and processed a total of 211 telemedicine claims. The current number of Medicaid participants is approximately 1.2 million and Medicaid participants typically utilize acute care services at a rate that is 50 — 60 percent higher than enrollees in a commercial plan. Given these considerations, the Department would expect that expanding telemedicine services would result in a total of approximately 169 telemedicine claims annually. Assuming that services delivered by telemedicine would incur an additional $23.72 in provider fees, the total cost of expanding telemedicine statewide would be approximately $25,320, subject to a federal reimbursement rate of 50 percent. The impact on the general fund would be $12,660.

Economic Impact on Small Businesses

The proposed action has a meaningful economic impact on small business. An analysis of this economic impact follows.

As stated above, the Department will reimburse eligible physicians and hospitals for providing health services via telemedicine.

Impact on Individuals with Disabilities

The proposed action has an impact on individuals with disabilities as follows:

Telemedicine services may improve access to health services for individuals with disabilities. Some individuals with disabilities may not need to travel long distances to see specialists if their providers participate in the telemedicine program(s).

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through November 3, 2014. A public hearing has not been scheduled.

.01 Scope.

A. This chapter applies to **[**two**]** telemedicine programs **[**— the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program**]** *reimbursed by the Maryland Medicaid Program effective October 1, 2014*.

B. (text unchanged)

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) "Campus" means the physical area immediately adjacent to the provider's main buildings, other areas, and structures that are not strictly contiguous to the main buildings but are located on the same property, and any other areas determined on an individual-case basis by the Department to be part of the provider's campus.

[(1)**]** *(2)*—**[(**2)**]** *(3)* (text unchanged)

[(3) "Designated rural geographic areas" means:

(a) Allegany County;

(b) Calvert County;

(c) Caroline County;

(d) Cecil County;

(e) Charles County;

(f) Carroll County;

(g) Dorchester County;

(h) Frederick County

(i) Garrett County;

(j) Harford County;

(k) Kent County;

(l) Queen Anne's County;

(m) Somerset County;

(n) St. Mary's County;

(o) Talbot County;

(p) Washington County;

(q) Wicomico County; and

(r) Worcester County.**]**

(4)—(6) (text unchanged)

(7) "Originating site" means the location of an eligible Medicaid participant at the time the service being furnished via technology-assisted communication occurs, which is a site approved by the Department to provide telemedicine services **[**and which:

(a) For the Rural Access Telemedicine Program, is located within a designated rural geographic area, in which an eligible participant is located at the time the telemedicine service is delivered; or

(b) For the Cardiovascular Disease and Stroke Telemedicine Program, is located in an emergency room when an appropriate specialist is not available**]**.

(8) "Originating site **[**facility**]** *transmission* fee" means the amount the Department reimburses an approved originating site for the telemedicine transmission.

(9) "Professional fee" means the Departmental fee schedule for clinical services which is incorporated by reference in COMAR **[**10.09.07.02**]** *10.09.02.07.*

(10)—(14) (text unchanged)

.03 Approval.

The Department shall grant approval to *allow* originating and consulting *site* providers to receive State and federal funds for providing telemedicine services if the telemedicine provider meets the requirements of this chapter.

.04 Service Model.

A.—C. (text unchanged)

D. Fee-for-service reimbursement for professional services shall be in accordance with the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR **[**10.09.07.02**]** *10.09.02.07.*

.05 Covered Services.

[A. Rural Access Telemedicine Program.

(1). Through the Rural Access Telemedicine Program, approved providers located in designated rural geographic areas may provide medically necessary services to Medical Assistance participants through technology-assisted communication.**]**

[(2)**]** Under the **[**Rural Access**]** Telemedicine Program, the Department shall cover:

[(a)**]** *A.* (text unchanged)

[(b)**]** *B.* Medically necessary consultation services covered by the Maryland Medical Assistance Program rendered by an approved consulting provider that can be delivered using technology-assisted communication; **[**and**]**

[(c)**]** *C*. An approved originating site for the originating site **[**facility**]** *transmission* fee*; and*

[B. Cardiovascular Disease and Stroke Telemedicine Program.

(1) Through the Cardiovascular Disease and Stroke Telemedicine Program, approved providers may render services to Medical Assistance participants in emergency departments where no specialist is available to provide timely consultation and diagnostic evaluation for cardiovascular disease or stroke care.

(2) Under the Cardiovascular Disease and Stroke Telemedicine Program, the Department shall cover:

(a) Medically necessary services covered by the Maryland Medical Assistance Program rendered by an approved originating site provider in a hospital emergency department setting for the treatment of cardiovascular disease or stroke that are distinct from the telemedicine services provided by a consulting provider;**]**

[(b)**]** *D.* The professional fee for an approved consulting provider for initial telemedicine consultation for services furnished before, during, and after communicating with the Medical Assistance participant presenting in a hospital emergency department setting **[**with cardiovascular disease or stroke**]** if:

[(i)**]** *(1)* (text unchanged)

[(ii)**]** *(2)* The initial telemedicine consultation is distinct from the care provided by the physician of record or the attending physician; **[**and**]**.

[(c) An approved originating site for the originating site facility fee for telemedicine services provided to a Medical Assistance participant for the treatment of cardiovascular disease or stroke if the telemedicine services rendered are:

(i) Medically necessary;

(ii) Provided in a hospital emergency department setting in the State; and

(iii) Provided when there are no specialists available at the originating site to provide a consultation and review diagnostic tests integral to the consultation in a timely manner.**]**

.06 Participant Eligibility.

A participant is eligible to receive telemedicine services if the individual:

A. (text unchanged)

B. **[**For the Rural Access Telemedicine Program, consents**]** *Consents* to telemedicine services unless there is an emergency that prevents obtaining consent, which the originating site shall document in the participant's medical record; and

C. (text unchanged)

.07 Provider Conditions for Participation.

A. To participate in the Program, the provider shall:

(1) Be enrolled as *a* Medical Assistance Program provider;

(2)—(5) (text unchanged)

B. **[**Rural Access Telemedicine Program**]** Approved Originating Site. The following sites may be approved as an originating site for **[**Rural Access**]** Telemedicine Program service delivery:

(1)—(6) (text unchanged)

C. **[**Rural Access Telemedicine Program**]** Approved Distant Site. The following provider types who practice within the State, the District of Columbia, or a contiguous state may be approved as consulting providers for **[**Rural Access**]** Telemedicine Program consultation services:

(1)—(3) (text unchanged)

[D. Cardiovascular Disease and Stroke Telemedicine Program Approved Originating Site. A Maryland hospital may be approved as an originating site for the Cardiovascular Disease and Stroke Telemedicine Program if no specialist is available to provide timely consultation and diagnostic evaluation for cardiovascular disease or stroke care.

E. Cardiovascular Disease and Stroke Telemedicine Program Approved Distant Site. Consulting specialty providers who practice within the State, the District of Columbia, or a contiguous state may be approved as consulting providers for Cardiovascular Disease and Stroke Telemedicine Program consultation services.**]**

.11 Limitations.

A.—H. (text unchanged)

I. The Department may not reimburse for home health monitoring services.

J. The Department may not reimburse for telemedicine services delivered by an originating and distant site provider located in different facilities in the same hospital campus.

.12 Reimbursement.

A. There are two categories of fees that the Department shall reimburse an approved telemedicine provider, as applicable:

(1) Originating site **[**facility**]** *transmission* fee; and

(2) (text unchanged)

B. Originating Site **[**Facility**]** *Transmission* Fee.

(1) The originating site facility fee is set:

(a) In the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR **[**10.09.07.02**]** *10.09.02.07*; or

(b) (text unchanged)

(2)—(3) (text unchanged)

C. (text unchanged)

JOSHUA M. SHARFSTEIN, M.D.
Secretary of Health and Mental Hygiene

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Appendix M: 2014 Telemedicine Reimbursement Legislation Tracking

The American Telemedicine Association maintains a summary of activity related to telemedicine among state legislatures in the U.S. For more information, please visit www.americantelemed.org.

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2014 State Telemedicine Legislation Tracking (as of 8/13/2014) *				
State	**Legislated Mandate for Private Coverage**	**Legislated Medicaid Coverage (primarily interactive video)**	**Other Proposed Bills Affecting Telemedicine Access or Coverage**	**Notes**
Alabama			✓	SB 336 and HB 334 - Telemedicine practice standards for optometry (STATUS: HB 334 Signed by Governor 4/8/14)
Alaska	Proposed		Proposed	HB 281 - Internet prescribing (STATUS: Sent to Gov); SB 80 - Parity, practice guidelines and out-of-state physician licensure (STATUS: CARYYOVER T0 2014 Session)
Arizona	✓		Proposed	SB 1339 - Codifies use of telemedicine in lieu of in-person visit for prescribing (STATUS: Signed by Governor 4/22/14); SB 1050 - Allow practice and reimbursement of telemedicine by naturopractic providers (STATUS: Passed the Senate and sent to the House); HB 2495 - Repeals telemedicine abortion prohibition; HB 2172 - Includes telemedicine in the scope of practice for psychologists (STATUS: Signed by Governor 4/22/14); SB 1353 (LAW EFFECTIVE 1/1/15)
Arkansas				
California	✓	✓	Proposed	AB 1310 - Medicaid distant site provider settings for telehealth; AB 2484 - Informed consent; AB 1771 - Cover and reimburse for physician telephonic and electronic patient management services; AB 809 - changes to informed consent for telemed; AB 318 - Medicaid coverage of dental care via store-and-forward; AB 1174 - Medicaid coverage of dental care via store-and-forward (STATUS: Approved by Assembly and sent to Senate); SB 1445 - Telehealth services and supports for individuals with developmental disabilities
Colorado	✓	✓		

2014 State Telemedicine Legislation Tracking (as of 8/13/2014) *				
State	**Legislated Mandate for Private Coverage**	**Legislated Medicaid Coverage (primarily interactive video)**	**Other Proposed Bills Affecting Telemedicine Access or Coverage**	**Notes**
Connecticut	Proposed		Proposed	SB 202 (STATUS: Died during session); HB 5378 - Medicaid demo for FQHCs; HB 5445 - Medicaid coverage of home telemonitoring (STATUS: Died during session)
Delaware				HB 359 - Practice standards for physical therapy and athletic training
DC	✓	✓		B20-0050 (LAW EFFECTIVE 10/17/13)
Florida	Proposed	Proposed	Proposed	SB 70 and HB 167; SB 1646--formerly SB 7028 - Out of state licensure, practice guidelines and telemedicine parity for Medicaid (STATUS: Died during session); HB 0751 (now part of CS/HB 7113) - practice guidelines (STATUS: Died during session)
Georgia	✓			
Hawaii	✓		✓	SB 2469 and HB 2411 - Amends existing law to include reimbursement parity for telehealth and revises scope of practice and definitions for physicians and APRNs (STATUS: Signed by Governor 6/30/14); SCR14 and HCR16 - Teledentistry study
Idaho			Proposed	HCR 46 - Develop a council to create state telehealth standards (STATUS: Passed both chambers and awaiting Gov. decision)
Illinois	Proposed		Proposed	SB 647 - private insurance coverage and reimbursement (STATUS: Sent to Governor); SB 3319 (new); HB 5313 (new); SB 1422 and SB 2366 (STATUS: CARYYOVER T0 2014 Session)
Indiana		✓	Proposed	SB 0346 - Medicaid reimbursement to pharmacists for medication therapy management via telehealth; HB 1258 - Telehealth Pilot (STATUS: Signed by Governor 3/24/14)
Iowa	Proposed	Proposed		HF 2160 (STATUS: Bill died in committee); HF 2307 - Allows the use of telemedicine in state-wide perinatal program (STATUS: Bill died in committee); SF 2156 - Telepharmacy licensure

2014 State Telemedicine Legislation Tracking (as of 8/13/2014) *				
State	**Legislated Mandate for Private Coverage**	**Legislated Medicaid Coverage (primarily interactive video)**	**Other Proposed Bills Affecting Telemedicine Access or Coverage**	**Notes**
Kansas			Proposed	HB 2690 - Parity coverage and reimbursement for telemental health; HB 2531 (new), SB 175, HB 2317, and HB 2395 - Autism diagnosis and treatment coverage (STATUS: All bills died in committee)
Kentucky	✓	✓		
Louisiana	✓	Proposed	✓	HB 1280 -- formerly HB 903 - Amends telemedicine practice guidelines for physicians; exemption for out-of-state consultations via telemedicine (STATUS: Signed by Governor 6/4/14) SB 501 - Amends telemedicine definition for licensed physicians; HB 1003 - Amends physician practice guidelines to allow the use of store-and-forward; HCR 88 - Creates telehealth taskforce
Maine	✓		Proposed	HB 1738 - Allow telemedicine use for consultations/medical exams during involuntary hospitalizations; LD 1596 - Review and amend telehealth rules for MaineCare
Maryland	✓	✓	✓	SB 198 and HB 802 - Lifting restrictions on Medicaid reimbursement of telemedicine-provided services (STATUS: Signed by Governor 4/14/14); SB 249 and HB 808 - Cybersecurity
Massachusetts	Proposed	Proposed	Proposed	S 2075 - Telemedicine private insurance parity for acute stroke services; H. 1951 - comprehensive mandate for all health plans including Medicaid; S.2312--formerly S. 530 - telemedicine study; H. 2114 - mandates coverage for telemedicine under private, Medicaid, and state employee plans; S. 467 - mandates coverage for private and state employee plans only; H. 948 - mandates coverage for telepsych services (STATUS: CARYYOVER T0 2014 Session)
Michigan	✓		✓	
Minnesota		✓	Proposed	HF 2171 - Coverage and reimbursement for teledental under Medicaid
Mississippi	✓	✓	✓	SB 2646 and HB 578 - Parity for store-and-forward and remote patient monitoring (STATUS: Signed by Governor 3/26/14); SB

2014 State Telemedicine Legislation Tracking (as of 8/13/2014) *				
State	**Legislated Mandate for Private Coverage**	**Legislated Medicaid Coverage (primarily interactive video)**	**Other Proposed Bills Affecting Telemedicine Access or Coverage**	**Notes**
				2015 and HB 396, 397, 457 - Authorizes Board of Health to develop rules for telemedicine (STATUS: SB 2015 sent to Governor); SB 2209 (LAW EFFECTIVE 7/1/13)
Missouri	✓	Proposed		SB 739 - Modifies Medicaid provisions related to out-of-state telehealth providers; HB 1837 - Coverage and reimbursement under Medicaid; HB 986--formerly SB 262 (LAW EFFECTIVE 1/1/14)
Montana	✓			SB 270 (LAW EFFECTIVE 1/1/14)
Nebraska	Proposed	✓	✓	LB 1017 - Revise guidelines for telepharmacy; LB 1078 and 1076 (STATUS: Signed by Governor 4/17/14); LB 505 and 605 - Telebehavioral (STATUS: CARRYOVER TO 2014 SESSION)
Nevada				
New Hampshire	✓		Proposed	HB 1158 - Requires managed care plans to offer financial incentives to beneficiaries who use less expensive services like telemedicine
New Jersey	Proposed	Proposed	Proposed	S 2338 - parity for managed care plans and state employee health plans; S 2337 - parity for Medicaid FFS and managed care; S 1204 and AB 2161 - Medicaid coverage and reimbursement of telemental health in FQHCs
New Mexico	✓		Proposed	SB 76 and HB 306 - Includes telemedicine in scope of practice for dental therapy-hygienist; SB 69 (LAW EFFECTIVE 7/4/13)
New York	Proposed	Proposed	Proposed	AB 4925 - Telepharmacy; S07852--formerly A09129 and S04337b - Requires telemedicine coverage under private insurance and Medicaid (STATUS: Sent to Governor); S04023 - Medicaid reimbursement for capital costs related to telemedicine
North Carolina				HB 704 - Telehealth study; SB 533 - Telehealth taskforce and study (STATUS: CARRYOVER TO 2014 SESSION)

2014 State Telemedicine Legislation Tracking (as of 8/13/2014) *				
State	**Legislated Mandate for Private Coverage**	**Legislated Medicaid Coverage (primarily interactive video)**	**Other Proposed Bills Affecting Telemedicine Access or Coverage**	**Notes**
North Dakota				
Ohio	Proposed	✓	Proposed	HB 519 - Telemedicine certificate; HB 123 (STATUS: SIGNED INTO LAW 2/18/13; LAW EFFECTIVE 5/20/14) and SB 166 - Medicaid expansion; SB 118 (STATUS: CARRYOVER TO 2014 SESSION)
Oklahoma	✓	Proposed	Proposed	HB 2399 - telemedicine reimbursement for Medicaid managed care; HB 3452 - Telemedicine for chronic disease screenings; HB 2089 - repeal informed consent for telemed (STATUS: CARRYOVER TO 2014 SESSION)
Oregon	✓		Proposed	SB 1560 - Adds self-insured health plans for state-employees to telemedicine parity law
Pennsylvania	Proposed		Proposed	HB 491; SB 1083 and HB 1655 - Establish patient-centered medical home model with consideration for telemedicine (STATUS: CARRYOVER TO 2014 SESSION)
Rhode Island	Proposed	Proposed	✓	H 7717; S 753, S 2513 and H 7137 - Licensure (STATUS: Signed by Governor 6/30/14)
South Carolina	Proposed			H 4899 - Allow telepractice for speech-language pathologists and audiologists; H 4901 (new); S 290 and H 3779 (STATUS: CARRYOVER TO 2014 Session)
South Dakota				
Tennessee	✓	✓		HB 1895 and SB 2050 (new) (STATUS: Signed by Governor 4/14/14); SB 484 and HB 923 (STATUS: CARYYOVER T0 2014 Session)
Texas	✓	✓		
Utah				
Vermont	✓	✓		
Virginia	✓			SB 647 - Teledentistry pilot (STATUS: Passed Senate and considered in House)
Washington	Proposed	Proposed		HB 1448 (STATUS: Died during session)
West Virginia	Proposed	Proposed		HB 4531

2014 State Telemedicine Legislation Tracking (as of 8/13/2014) *				
State	**Legislated Mandate for Private Coverage**	**Legislated Medicaid Coverage (primarily interactive video)**	**Other Proposed Bills Affecting Telemedicine Access or Coverage**	**Notes**
Wisconsin			✓	AB 458 and SB 410 - amends practice guidelines for telemental health providers (STATUS: ENACTED)
Wyoming				
* Does Not Include State Administrative or Regulatory Orders				
✓= Previously Enacted				

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Appendix N: Md. Code Ann., Health - General §19–319

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Md. HEALTH-GENERAL Code Ann. § 19-319

§ 19-319 Qualifications for licenses

(a) In general. -- To qualify for a license, an applicant and the hospital or related institution to be operated shall meet the requirements of this section.

(b) Applicant. -- An applicant who is an individual, and any individual who is applying on behalf of a corporation, association, or government agency shall be:

(1) At least 18 years old; and

(2) Of reputable and responsible character.

(c) Hospital, residential treatment center, or related institution. --

(1) The applicant shall have a certificate of need, as required under Subtitle 1 of this title, for the hospital, residential treatment center, or related institution to be operated.

(2) The hospital, residential treatment center, or related institution to be operated shall meet the requirements that the Secretary adopts under this subtitle and Subtitle 12 of this title.

(d) Utilization review program. --

(1) As a condition of licensure, each hospital shall establish a utilization review program for all patients admitted to the hospital. The utilization review program:

(i) May be conducted by an independent, nonhospital-affiliated review agent;

(ii) Shall be performed by registered nurses, medical records technicians, or similar qualified personnel supported and supervised by physicians as may be required;

(iii) Shall be certified by the Secretary if the program meets the minimum standards established under paragraph (4) of this subsection; and

(iv) Shall be recertified by the Secretary if the hospital makes any changes to the program after the initial certification.

(2) Any change made to a certified utilization review program shall be reported to the Secretary by the hospital within 30 days of the date the change was made.

(3) If a hospital fails to provide the utilization review program required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of hospital; or

(ii) $ 500 per day for each day the violation continues.

(4) The Secretary shall, by regulation and in consultation with health care providers and payors, establish minimum standards for a utilization review program, directed at appropriateness and quality of inpatient care, as enumerated in the following items:

(i) Preadmission review of elective admissions;

(ii) Postadmission review of emergency admissions;

(iii) Concurrent or retrospective review of all admissions as appropriate;

(iv) Preauthorization of certain selected procedures if proposed to be performed on an inpatient basis;

(v) Continued stay review based on recognized objective criteria;

(vi) Discharge planning review; and

(vii) Readmission review.

(5) A patient may not be charged for any days disallowed as a result of retrospective review under paragraph (4) of this subsection unless the patient refuses to leave the hospital when it is medically appropriate to do so and the disallowed days occur:

(i) After the hospital has notified the patient in writing of the potential disallowance; or

(ii) As a direct result of the noncompliance by the patient to treatment or hospital regulations.

(6) A hospital shall be exempt from requiring a utilization review program for a patient if:

(i) 1. The patient is insured by a third-party payor; and

2. The third-party payor has a utilization review program for its subscribers or beneficiaries which meets the minimum standards as adopted in paragraph (4) of this subsection; or

(ii) The patient is a subscriber or member of a health maintenance organization as defined in § 19-701 of this title.

(7) Where federal regulations or guidelines for a federally mandated utilization review program for federally insured patients differ from standards established under paragraph (4) of this subsection, the Secretary may waive a specific standard if the program achieves the same objectives as the standards established by the Secretary.

(8) The Secretary may establish record keeping and reporting requirements:

(i) To evaluate the effectiveness of hospitals' utilization review programs; and

(ii) To determine if the utilization review programs are in compliance with the provisions of this section and regulations adopted by the Secretary to administer this section.

(e) Definitions. --

(1) (i) In this subsection the following words have the meanings indicated.

(ii) 1. "Telemedicine" means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

2. "Telemedicine" does not include:

A. An audio-only telephone conversation between a physician and a patient;

B. An electronic mail message between a physician and a patient; or

C. A facsimile transmission between a physician and a patient.

(iii) "Uniform standard credentialing form" means:

1. The form designated by the Secretary through regulation for credentialing physicians who seek to be employed by or have staff privileges at a hospital; or

2. The uniform credentialing form that the Insurance Commissioner designates under § 15-112.1 of the Insurance Article.

(2) As a condition of licensure, each hospital shall:

(i) Establish a credentialing process for the physicians who are employed by or who have staff privileges at the hospital; and

(ii) Use the uniform standard credentialing form as the initial application of a physician seeking to be credentialed.

(3) Use of the uniform standard credentialing form does not preclude a hospital from requiring supplemental or additional information as part of the hospital's credentialing process.

(4) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar, establish minimum standards for a credentialing process which shall include:

(i) A formal written appointment process documenting the physician's education, clinical expertise, licensure history, insurance history, medical history, claims history, and professional experience.

(ii) A requirement that an initial appointment to staff not be complete until the physician has successfully completed a probationary period.

(iii) A formal, written reappointment process to be conducted at least every 2 years. The reappointment process shall document the physician's pattern of performance by analyzing:

1. Claims filed against the physician;

2. Data dealing with utilization, quality, and risk;

3. Clinical skills;

4. Adherence to hospital bylaws, policies, and procedures;

5. Compliance with continuing education requirements;

6. Mental and physical status; and

7. The results of the practitioner performance evaluation process under subsection (i) of this section.

(5) If requested by the Department, a hospital shall provide documentation that, prior to employing or granting privileges to a physician, the hospital has complied with the requirements of this subsection and that, prior to renewing employment or privileges, the hospital has complied with the requirements of this subsection.

(6) Notwithstanding any other provision of this subsection, in its credentialing and privileging process for a physician who provides medical services to patients at the hospital only through telemedicine from a distant-site hospital or distant-site telemedicine entity, a hospital may rely on the credentialing and privileging decisions made for the physician by the distant-site hospital or distant-site telemedicine entity, as authorized under 42 C.F.R. Part 482, if:

(i) The physician who provides medical services through telemedicine holds a license to practice medicine in the State issued under Title 14 of the Health Occupations Article; and

(ii) The credentialing and privileging decisions with respect to the physician who provides medical services through telemedicine are:

1. Approved by the medical staff of the hospital; and

2. Recommended by the medical staff of the hospital to the hospital's governing body.

(7) If a hospital fails to establish or maintain a credentialing process required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of the hospital; or

(ii) $ 500 per day for each day the violation continues.

(f) Procurement of organs and tissues. -- As a condition of licensure, each accredited and nonaccredited hospital shall develop a protocol for the procurement of organs and tissues.

(g) Risk management program. --

(1) As a condition of licensure, each hospital shall establish a risk management program.

(2) The Secretary shall, by regulation and in consultation with hospitals, physicians, interested community and advocacy groups, and representatives of the Maryland Defense Bar and Plaintiffs' Bar establish minimum standards for a risk management program which shall include:

(i) A board policy statement indicating commitment to the risk management program;

(ii) A requirement that one person be assigned the responsibility for coordinating the program;

(iii) An internal staff committee structure to conduct ongoing review and evaluation of risk management activities;

(iv) A formal written program for addressing patient complaints;

(v) A documented facility-wide risk reporting system;

(vi) Ongoing risk management education programs for all staff; and

(vii) Documentation that the risk management and quality assurance programs share relevant information.

(3) If a hospital fails to establish or maintain a risk management program required under this subsection, the Secretary may impose the following penalties:

(i) Delicensure of the hospital; or

(ii) $ 500 per day for each day the violation continues.

(h) Compliance with and notice explaining Centers for Disease Control and Prevention's guidelines on universal precautions. --

(1) As a condition of licensure, each hospital and related institution shall:

(i) Adopt, implement, and enforce a policy that requires, except in an emergency life-threatening situation where it is not feasible or practicable, all employees and medical staff involved in patient care services to comply with the Centers for Disease Control and Prevention guidelines on universal precautions; and

(ii) Display the notice developed under § 1-207 of the Health Occupations Article at the entrance to the hospital or related institution.

(2) If a hospital or related institution fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to $ 500 per day per violation for each day a violation continues.

(i) Practitioner performance evaluation process. --

(1) As a condition of licensure, each hospital shall establish a practitioner performance evaluation process that objectively evaluates the performance of each member of the medical staff at the hospital.

(2) The practitioner performance evaluation process shall include a review of care provided to patients at the hospital by the members of the medical staff.

(3) The review of care shall:

(i) Be undertaken for cases chosen at random and for cases with unexpected adverse outcomes;

(ii) Be based on objective review standards;

(iii) Include a review of the appropriateness of the plan of care for the patient, particularly any medical procedures performed on the patient, in relation to the patient's condition; and

(iv) Be conducted by members of the medical staff or, at the discretion of the hospital, external reviewers, who:

1. Are of the same specialty as the member of the medical staff under review;

2. Have been trained to perform practitioner performance evaluation; and

3. Are not otherwise associated with the case under review.

(4) A hospital shall take into account the results of the practitioner performance evaluation process for a member of the medical staff in the reappointment process established under subsection (e) of this section.

(5) If a hospital fails to comply with the requirements of this subsection, the Secretary may impose a fine of up to $ 500 per day per violation for each day a violation continues.

HISTORY: An. Code 1957, art. 43, §§ 559, 560; 1982, ch. 21, § 2; ch. 107, § 1; 1985, ch. 111; 1986, ch. 5, § 1; ch. 642, § 3; chs. 673, 690, 733; 1990, ch. 671; 1992, ch. 154, § 1; ch. 581; 1993, ch. 99; 1997, ch. 130; 2002, ch. 189; 2003, ch. 21, § 1; 2004, ch. 25, §§ 1, 6; 2006, ch. 232; 2009, chs. 90, 91; 2011, ch. 587; 2013, ch. 324.

NOTES: EFFECT OF AMENDMENTS. --Chapters 90 and 91, Acts 2009, effective October 1, 2009, made identical changes. Each added (e)(1)(ii), redesignated accordingly and made related changes

Chapter 587, Acts 2011, effective October 1, 2011, reenacted (a) without change; rewrote (e)(4)(iii) without substantive change; and added (i).

Chapter 324, Acts 2013, effective October 1, 2013, rewrote (e)(1) and added (e)(6) and redesignated accordingly.

End quoted text

Appendix O: COMAR 10.07.01, .09, .24, and .29

Begin quoted text

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 07 HOSPITALS

10.07.01 Acute General Hospitals and Special Hospitals

Authority: Health-General Article, §§19-307.2, 19-308, 19-308.8, 19-318—19-320, 19-323, and 19-349.1; Insurance Article, Title 4, Subtitle 4; Public Safety Article, §14-110.1; Annotated Code of Maryland

10.07.01

.01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Accredited hospital" means a hospital accredited by The Joint Commission or other accreditation organization approved by the Department.

(2) "Accredited special rehabilitation hospital" means a hospital that is accredited by the Commission on Accreditation of Rehabilitation Facilities for providing comprehensive physical rehabilitation services.

(2-1) "Accreditation organization" means a private entity that conducts inspections and surveys of health care facilities based on nationally recognized and developed standards.

(3) "Administrative day" means a day of care rendered to a patient who no longer requires the level of care the hospital is licensed to provide.

(4) "Admission" means the formal acceptance by a hospital of a patient who is to be provided with room, board, and medical services.

(5) "Agent" means the individual or individuals, or organization that shall conduct utilization review activities in fulfillment of a hospital's responsibilities under these regulations. The agent may be a hospital employee or employees, or it may be an independent group or organization.

(6) "Appointment" means designation of a physician to have staff privileges at the hospital.

(6-1) "Calculated licensed bed capacity" means the total number of inpatient beds recalculated annually as 140 percent of a general hospital's average daily census as determined by the Health Services Cost Review Commission for the most recent 12-month period.

(7) "Claim" means a written demand for damages as a result of alleged professional malpractice.

(8) "Commission on Accreditation of Rehabilitation Facilities" means the private, nonprofit organization formed in 1966 which has established standards of quality for rehabilitation services and accredits those who provide the services.

(9) "Comprehensive physical rehabilitation services" has the same meaning as defined in Health-General Article, §19-1201(b), Annotated Code of Maryland.

(10) "Credentialing process" means the process by which a hospital:

(a) Verifies qualifications of a physician;

(b) Delineates clinical privileges of a physician; and

(c) Monitors performance of a physician.

(11) "Department" means the Department of Health and Mental Hygiene.

(12) "Elective", when applied to admission or to a health care service, means an admission or service that can be delayed without substantial risk to the health of the individual.

(12-1) "Healthcare-associated infection" means an infection that:

(a) Develops in a patient who is cared for in any setting where healthcare is delivered; and

(b) Was not incubating or present at the time the healthcare was provided.

(13) "Hospital" means an institution that:

(a) Has a group of at least five physicians who are organized as a medical staff for the institution;

(b) Maintains facilities to provide, under the supervision of the medical staff, diagnostic and treatment services for two or more unrelated individuals; and

(c) Admits or retains the individuals for overnight care.

(14) "Incident" means any circumstance or occurrence that may be injurious to a patient or that may result in an adverse outcome to a patient.

(15) "The Joint Commission" means the voluntary national healthcare accreditation service recognized for Medicare certification purposes by Public Law 89-97 and for Maryland State licensure purposes by Health-General Article, §19-2302, Annotated Code of Maryland.

(16) "License" means a license issued by the Secretary to operate a hospital in this State.

(17) "Long-term care" means, for the purpose of this chapter, care provided in a hospital, but is designed to treat conditions requiring treatment at a level below that of acute hospital care.

(18) "Maryland Medical Assistance Program" means the program administered by the State under Title XIX of the Social Security Act which provides comprehensive medical and other health-related care for eligible categorically and medically needy persons. For the purpose of this chapter, this shall include those persons provided care under the program administered and financed by the State for eligible needy persons who do not meet the technical requirements of federally funded Medical Assistance.

(19) "Medicare Program" means the federal program of health insurance for the aged and disabled established pursuant to 42 U.S.C. §1395 et seq.

(20) "Nonaccredited hospital" means a:

(a) Hospital not accredited by The Joint Commission or other accreditation organization approved by the Department; or

(b) Special rehabilitation hospital not accredited by The Joint Commission.

(21) "Nonelective", when applied to admission or to a health care service, means an admission or service that cannot be delayed without substantial risk to the health of the individual.

(22) "Physician" has the meaning stated under Health Occupations Article, §14-101(j), Annotated Code of Maryland.

(23) "Plan" means a thorough written specification of how the elements of review required by these regulations shall be performed.

(24) "Privilege" means the authority granted to a physician by a hospital to:

(a) Admit patients to the hospital; or

(b) Perform specific procedures or treatments on patients at the hospital.

(25) "Secretary" means the Secretary of Health and Mental Hygiene.

(26) "Specialized rehabilitation program" has the meaning stated in Health-General Article, §19-1201(e), Annotated Code of Maryland.

(26-1) Telemedicine

(a) “Telemedicine” means the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.

(b) “Telemedicine” does not include:

(i) An audio only telephone conversation between the physician and patient;

(ii) An electronic mail message between a physician and a patient; or

(iii) A facsimile transmission between a physician and a patient.

(27) "Unexpected adverse outcomes" means unanticipated negative outcomes related to a patient’s medical treatment and not related to the natural course of the patient’s illness or underlying disease condition.

(27-1) “Uniform standard credentialing form” means:

(a) The form designated by the Department through COMAR 10.07.01.24C(6) for credentialing physicians who seek to be employed by or have staff privileges at a hospital; or

(b) The uniform credentialing form that the Insurance Commissioner designates under Insurance Article, §15–112.1, Annotated Code of Maryland.

(28) "Utilization review" means a system for reviewing the appropriate and efficient allocation of hospital resources and services given or proposed to be given to a patient or group of patients.

(29) "Utilization review plan" means a description of the standards governing utilization review activities performed by a private review agent or hospital utilization review agent.

.09 Service Standards — Non-Accredited Hospitals.

A. Acute General Hospitals and Special Hospitals. The 2013 Hospital Accreditation Standards (July Update, The Joint Commission, One Renaissance Blvd., Oakbrook, Illinois 60181), is incorporated by reference.

B. Waiver Authority. The Secretary may, for good cause, waive compliance with the incorporated Joint Commission standards. The hospital shall justify the need for the waiver in the manner prescribed by the Department.

.24 Physician Credentialing Process.

A. General. In accordance with this regulation, a hospital shall have in effect a credentialing process.

B. Scope of Credentialing Process. The credentialing process shall apply to any physician who shall admit or treat patients in the hospital.

C. Specific Standard — Appointment and Employment Process.

(1) In accordance with this section, a hospital shall establish a formal written process for the appointment or employment of a physician by the hospital.

(2) The term of an appointment shall be 2 years or less.

(3) The formal written appointment or employment process shall provide for a probationary period that shall be successfully completed before the finalization of the appointment or employment of the physician.

(4) As part of the formal written appointment and employment process, the hospital shall collect, verify, review, and document the following information about the physician:

(a) The physician's education;

(b) The clinical expertise of the physician;

(c) The professional experience of the physician including:

(i) Any board certification or specialty training of the physician;

(ii) The internship of the physician; and

(iii) The residencies of the physician;

(d) Any license or registration to practice a health occupation ever held by the physician, including:

(i) A license to practice medicine; and

(ii) DEA registration;

(e) Whether any license or registration to practice a health occupation ever held by the physician has been:

(i) Suspended;

(ii) Revoked;

(iii) Voluntarily surrendered or not renewed;

(f) Concerning any hospital where the physician was appointed or employed:

(i) The name of the hospital;

(ii) The term of appointment or employment;

(iii) Privileges held and any disciplinary action taken on the privileges, including suspension, revocation, limitation, or voluntary surrender;

(g) Concerning the physician's professional liability insurance:

(i) The physician's present carrier;

(ii) The physician's current limits of coverage;

(iii) The physician's current types of coverage;

(iv) Restrictions on the physician's coverage; and

(v) Whether or not the physician has maintained continuous malpractice coverage since first obtaining professional insurance;

(h) Any claim that has been made against the physician in the practice of any health occupation and the status of the claim;

(i) The physician's medical history including the physician's current mental and physical health status;

(j) A complaint or report filed with:

(i) The Board of Physicians or any other state medical discipline agency;

(ii) A state medical society;

(iii) A state disciplinary body; or

(iv) A professional or specialty association.

(5) The formal written process shall provide for the documentation of any action taken by the hospital regarding the appointment or employment of the physician.

(6) Uniform Standard Credentialing Form.

(a) A hospital shall use the uniform standard credentialing form approved by the Department for the initial credentialing of a physician seeking appointment or employment.

(b) Use of the uniform standard credentialing form does not preclude a hospital from requiring additional information, attestations, or supplemental documentation as required by that hospital's credentialing process.

(c) A physician seeking hospital privileges shall submit an updated and complete uniform standard credentialing form at the time of application to each hospital.

D. Specific Standard—Granting of Delineated Clinical Privileges.

(1) In accordance with this section, a hospital shall establish a formal written process for the granting of delineated clinical privileges.

(2) The formal written process shall include:

(a) Criteria for determining whether a physician shall be granted privileges by the hospital to provide specific services;

(b) Criteria for ongoing evaluation of the performance of the services for which privileges have been granted;

(c) Procedures for altering, suspending, or revoking the delineated privileges.

(3) The formal written process shall provide for documentation of any actions taken regarding delineated privileges.

E. Specific Standard—Reappointment.

(1) In accordance with this section, a hospital shall establish a formal written process for the reappointment of a physician who has been appointed to the hospital.

(2) The term of reappointment shall be 2 years or less.

(3) As part of the formal written appointment process, a hospital shall collect, verify, review, and document the following information about the physician:

(a) An update of the information regarding appointment under §C of this regulation;

(b) Concerning the physician's pattern of performance based on an analysis of the following:

(i) Claims filed against the physician;

(ii) Utilization, quality and risk data;

(iii) A review of clinical skills;

(iv) Adherence to hospital bylaws, policies, and procedures;

(v) Compliance with continuing medical education requirements;

(vi) An assessment of current mental and physical health status;

(vii) Attitudes, cooperation, and the ability to work with others; and

(viii) The results of the Practitioner Performance Evaluation process as described in Health-General Article, §§19-3B-01—19-3B-09, Annotated Code of Maryland.

F. Specific Standard—Record Maintenance.

(1) In accordance with this section, a hospital shall maintain a separate credentialing file for each physician.

(2) The credentialing file for each physician shall contain documentation relating to the credentialing process required under this regulation.

G. Disaster Privileges.

(1) During an emergency or disaster in which the hospital's disaster or emergency management plan has been activated, when the Governor has declared that a state of emergency exists, or when the Secretary has issued an order pursuant to Health-General Article, §18-905, Annotated Code of Maryland, the chief executive officer, medical staff president, or designee may grant temporary disaster privileges to licensed physicians who have not been appointed to the hospital's medical staff.

(2) The hospital shall develop a medical staff plan for the granting of disaster privileges that identifies:

(a) The individual responsible for granting disaster privileges;

(b) The responsibilities of that individual;

(c) A system to manage, assign, and supervise the physicians who have been granted disaster privileges; and

(d) The process by which credentials and privileges are verified as soon as the situation allows, ensuring that the process complies with §C of this regulation.

(3) Physicians granted disaster privileges by a hospital shall:

(a) Be registered and trained by the Department as part of the Department's Maryland Physician Volunteer Corps and possess the Department issued photo identification; or

(b) Comply with the hospital's medical staff plan for granting privileges in a disaster, which shall require at least one of the following:

(i) Presentation of a current Maryland license to practice medicine and a valid identification picture (ID) issued by a state, federal, or regulatory agency;

(ii) Presentation of a license to practice medicine from another state if a state of emergency has been declared by the Governor and the assistance of the physician has been requested by Maryland pursuant to the Emergency Management Assistance Compact, Public Safety Article, §14-702, Annotated Code of Maryland;

(iii) Presentation of a current photo identification card from another Maryland hospital where the physician is a member of the medical staff; or

(iv) Verification by a current member of the hospital's medical staff who has personal knowledge regarding the practitioner's identity and current Maryland medical licensure.

(4) Disaster privileges shall be discontinued when the hospital's chief executive officer, medical staff president, or designee determines that the emergency condition no longer exists and that the hospital has adequate resources to meet the patient's needs.

(5) The hospital shall maintain records that include:

(a) The number of hours worked by each physician;

(b) The type of service provided by each physician;

(c) The location where these services were provided; and

(d) Any additional information required by the Department for federal and State reimbursement.

H. Telemedicine. Notwithstanding any other provision of COMAR 10.07.01.24, in its credentialing and privileging process for a physician who provides medical services to the patients at the hospital only through telemedicine from a distant-site hospital or distant-site telemedicine entity, a hospital may rely on the credentialing and privileging decisions made for the physician by the distant-site hospital or distant-site telemedicine entity as authorized under 42 C.F.R. Part 482, if:

(1) The physician who provides medical services through telemedicine holds a license to practice medicine in the State under Health Occupations Article, Title 14, Annotated Code of Maryland; and

(2) The credentialing and privileging decisions with respect to the physician who provides medical services through telemedicine are:

(a) Approved by the medical staff of the hospital; and

(b) Recommended by the medical staff of the hospital to the hospital's governing body.

I. Request for Documentation by Department. On request from the Department, a hospital shall provide documentation that before:

(1) Appointment or employment of a physician or granting delineated privileges, the hospital has complied with the requirements of this regulation; and

(2) Reappointment or renewing of employment or specific privileges, the hospital has complied with the requirements of this regulation.

J. Penalties. If a hospital fails to have in effect a credentialing process in accordance with these regulations, the Secretary may impose upon the hospital the following penalties:

(1) Delicensure of the hospital; or

(2) A fine of $500 for each day that the hospital is in violation of these regulations.

.29 Notice to Patients of Outpatient on Observation Status.

A. A hospital shall provide both an oral and written notice to a patient of:

(1) The patient's outpatient on observation status;

(2) The billing implications of the outpatient on observation status; and

(3) The impact of the outpatient on observation status on the patient's eligibility for Medicare rehabilitation services if:

(a) The patient received on-site services from the hospital for more than 23 consecutive hours;

(b) The on-site services received by the patient include a hospital bed and meals that have been provided in an area of the hospital other than the Emergency Department; and

(c) The patient is classified as an outpatient at the hospital for observation rather than as an admitted inpatient.

B. The written notice shall include:

(1) That the patient is considered to be on observation as an outpatient and is not admitted as an inpatient;

(2) The reason or rationale that the patient has not been admitted for inpatient services;

(3) That the patient, if needed upon discharge, may not qualify for Medicare Part A reimbursement for rehabilitation services, including such services provided under Medicare Part A in a skilled nursing facility;

(4) That there may be billing implications based on their outpatient status that may increase the patient's out-of-pocket costs for their stay;

(5) The name and title of the staff who provided the oral notice stating the date and time of the oral notice; and

(6) The signature of the patient to verify an understanding and receipt of the written notice.

C. Once the patient has received onsite services for more than 23 hours, the hospital shall provide written and oral notice to the patient that the physician has ordered services be provided as outpatient on observation status.

D. The oral and written notice shall be provided in a manner that is understood by the patient.

E. If the patient lacks capacity to understand the medical or financial implications of his or her outpatient on observation status, the oral and written notice shall be provided to a person authorized to make medical or financial decisions for the patient, including:

(1) A guardian of the person under Estates and Trusts Article, §13-705, Annotated Code of Maryland;

(2) A guardian of the property under Estates and Trusts Article, §13-201, Annotated Code of Maryland;

(3) An agent appointed under an advance directive that meets the requirements of Health-General Article, §5-602, Annotated Code of Maryland;

(4) A surrogate decision maker with authority under Health-General Article, §5-605, Annotated Code of Maryland;

(5) An agent appointed under a power of attorney that meets the requirements of Estates and Trusts Article, Title 17, Annotated Code of Maryland;

(6) A representative payee or other similar fiduciary; or

(7) Any other person, if that person was designated by the patient who was competent at the time of designation, and the patient or representative has provided the hospital with documentation of the designation.

End quoted text

Appendix P: Md. Code Ann., Health - General § 15-105.2

Begin quoted text

Md. HEALTH-GENERAL Code Ann. § 15-105.2

§ 15-105.2. Reimbursement to health care providers

(a) In general. -- The Program shall reimburse health care providers in accordance with the requirements of Title 19, Subtitle 1, Part IV of this article.

(b) Telemedicine reimbursements. --

(1) Subject to paragraph (2) of this subsection and unless otherwise specifically prohibited or limited by federal or State law, the Program shall reimburse a health care provider for a health care service delivered by telemedicine, as defined in *§ 15-139 of the Insurance Article*, in the same manner as the same health care service is reimbursed when delivered in person.

(2) Reimbursement under paragraph (1) of this subsection is required only for a health care service that:

(i) Is medically necessary; and

(ii) Is provided:

1. For the treatment of cardiovascular disease or stroke;

2. In an emergency department setting; and

3. When an appropriate specialist is not available.

(3) The Department shall adopt regulations to carry out this subsection.

HISTORY: 2009, ch. 689; 2013, ch. 280.

NOTES: EFFECT OF AMENDMENTS. --Chapter 280, Acts 2013, effective October 1, 2013, added the (a) designation and added (b).

End quoted text

Appendix Q: Maryland Medicaid Telemedicine Regulations COMAR 10.09.49

Begin quoted text

Title 10

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 09 MEDICAL CARE PROGRAMS

Chapter 49 Telemedicine Services

10.09.49 Telemedicine Services

Authority: Health-General Article, §2-104(b), Annotated Code of Maryland; Ch. 280, Acts of 2013

.01 Scope.

A. This chapter applies to two telemedicine programs — the Rural Access Telemedicine Program and the Cardiovascular Disease and Stroke Telemedicine Program.

B. The purpose of providing medically necessary services via telemedicine is to improve:

(1) Access to outpatient specialty care, thus reducing preventable hospitalizations and reducing barriers to health care access;

(2) Patient compliance with treatment plans;

(3) Health outcomes through timely disease detection and treatment options; and

(4) Capacity and choice for outpatient ongoing treatment in underserved areas of the State.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) “Consulting provider” means the licensed provider at the distant site who provides medically necessary consultation services to the patient at the originating site via telemedicine upon request from the originating site provider.

(2) “Department” means the Department of Health and Mental Hygiene, which is the single State agency designated to administer the telemedicine program.

(3) "Designated rural geographic areas" means:

(a) Allegany County;

(b) Calvert County;

(c) Caroline County;

(d) Cecil County;

(e) Charles County;

(f) Carroll County;

(g) Dorchester County;

(h) Frederick County

(i) Garrett County;

(j) Harford County;

(k) Kent County;

(l) Queen Anne's County;

(m) Somerset County;

(n) St. Mary's County;

(o) Talbot County;

(p) Washington County;

(q) Wicomico County; and

(r) Worcester County.

(4) "Distant site" means a site approved by the Department to provide telemedicine services, at which the licensed consulting provider is located at the time the service is provided via technology-assisted communication.

(5) "Federally qualified health center (FQHC)" has the meaning stated in Health-General Article, §24-1301, Annotated Code of Maryland.

(6) "Medically necessary" means that the service or benefit is:

(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;

(b) Consistent with currently accepted standards of good medical practice;

(c) The most cost-efficient service that can be provided without sacrificing effectiveness or access to care; and

(d) Not primarily for the convenience of the consumer, family, or provider.

(7) "Originating site" means the location of an eligible Medicaid participant at the time the service being furnished via technology-assisted communication occurs, which is a site approved by the Department to provide telemedicine services and which:

(a) For the Rural Access Telemedicine Program, is located within a designated rural geographic area, in which an eligible participant is located at the time the telemedicine service is delivered; or

(b) For the Cardiovascular Disease and Stroke Telemedicine Program, is located in an emergency room when an appropriate specialist is not available.

(8) "Originating site facility fee" means the amount the Department reimburses an approved originating site for the telemedicine transmission.

(9) "Professional fee" means the Departmental fee schedule for clinical services which is incorporated by reference in COMAR 10.09.07.02.

(10) “Provider” means:

(a) An individual, association, partnership, corporation, unincorporated group, or any other person authorized, licensed, or certified to provide services for Medical Assistance participants and who, through appropriate agreement with the Department, has been identified as a Maryland Medical Assistance Provider by the issuance of an individual account number;

(b) An agent, employee, or related party of a person identified in §B(10)(a) of this regulation; or

(c) An individual or any other person with an ownership interest in a person identified in §B(10)(a) of this regulation.

(11) "Security" means the protection of information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction.

(12) “Store and Forward technology” means the transmission of medical images or other media captured by the originating site provider and sent electronically to a distant site provider, who does not physically interact with the patient located at the originating site.

(13) “Technology-assisted communication” means multimedia communication equipment permitting two-way real-time interactive communication between a patient at an originating site and a consulting provider at a distant site.

(14) “Telemedicine” means the delivery of medically necessary services to a patient at an originating site by a consulting provider, through the use of technology-assisted communication.

.03 Approval.

The Department shall grant approval to originating and consulting providers to receive State and federal funds for providing telemedicine services if the telemedicine provider meets the requirements of this chapter.

.04 Service Model.

A. Telemedicine improves access to consulting providers from other areas of the State, the District of Columbia, or a contiguous state.

B. Telemedicine providers may be part of a private practice, hospital, or other health care system.

C. Medical Assistance-approved originating site providers shall engage in agreements with consulting providers for telemedicine services.

D. Fee-for-service reimbursement for professional services shall be in accordance with the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.07.02.

.05 Covered Services.

A. Rural Access Telemedicine Program.

(1) Through the Rural Access Telemedicine Program, approved providers located in designated rural geographic areas may provide medically necessary services to Medical Assistance participants through technology-assisted communication.

(2) Under the Rural Access Telemedicine Program, the Department shall cover:

(a) Medically necessary services covered by the Maryland Medical Assistance Program rendered by an originating site provider that are distinct from the telemedicine services provided by a consulting provider;

(b) Medically necessary consultation services covered by the Maryland Medical Assistance Program rendered by an approved consulting provider that can be delivered using technology-assisted communication; and

(c) An approved originating site for the originating site facility fee.

B. Cardiovascular Disease and Stroke Telemedicine Program.

(1) Through the Cardiovascular Disease and Stroke Telemedicine Program, approved providers may render services to Medical Assistance participants in emergency departments where no specialist is available to provide timely consultation and diagnostic evaluation for cardiovascular disease or stroke care.

(2) Under the Cardiovascular Disease and Stroke Telemedicine Program, the Department shall cover:

(a) Medically necessary services covered by the Maryland Medical Assistance Program rendered by an approved originating site provider in a hospital emergency department setting for the treatment of cardiovascular disease or stroke that are distinct from the telemedicine services provided by a consulting provider;

(b) The professional fee for an approved consulting provider for initial telemedicine consultation for services furnished before, during, and after communicating with the Medical Assistance participant presenting in a hospital emergency department setting with cardiovascular disease or stroke if:

(i) The consulting provider is not the physician of record or the attending physician; and

(ii) The initial telemedicine consultation is distinct from the care provided by the physician of record or the attending physician; and

(c) An approved originating site for the originating site facility fee for telemedicine services provided to a Medical Assistance participant for the treatment of cardiovascular disease or stroke if the telemedicine services rendered are:

(i) Medically necessary;

(ii) Provided in a hospital emergency department setting in the State; and

(iii) Provided when there are no specialists available at the originating site to provide a consultation and review diagnostic tests integral to the consultation in a timely manner.

.06 Participant Eligibility.

A participant is eligible to receive telemedicine services if the individual:

A. Is enrolled in the Maryland Medical Assistance Program;

B. For the Rural Access Telemedicine Program, consents to telemedicine services unless there is an emergency that prevents obtaining consent, which the originating site shall document in the participant's medical record; and

C. Is present at the originating site at the time the telemedicine service is rendered.

.07 Provider Conditions for Participation.

A. To participate in the Program, the provider shall:

(1) Be enrolled as Medical Assistance Program provider;

(2) Meet the requirements for participation in the Maryland Medical Assistance Program as set forth in:

(a) COMAR 10.09.36.02;

(b) COMAR 10.09.36.03; and

(c) The COMAR chapter defining the covered service being rendered;

(3) Apply for participation in the Program using the application form designated by the Department;

(4) Be approved for participation by the Department; and

(5) Have a written contingency plan when telemedicine is unavailable.

B. Rural Access Telemedicine Program Approved Originating Site. The following sites may be approved as an originating site for Rural Access Telemedicine Program service delivery:

(1) A FQHC;

(2) A hospital, including the emergency department;

(3) The office of a physician, nurse practitioner, or nurse midwife;

(4) A renal dialysis center;

(5) A local health department; and

(6) A nursing facility.

C. Rural Access Telemedicine Program Approved Distant Site. The following provider types who practice within the State, the District of Columbia, or a contiguous state may be approved as consulting providers for Rural Access Telemedicine Program consultation services:

(1) A physician;

(2) A nurse practitioner; and

(3) A nurse midwife.

D. Cardiovascular Disease and Stroke Telemedicine Program Approved Originating Site. A Maryland hospital may be approved as an originating site for the Cardiovascular Disease and Stroke Telemedicine Program if no specialist is available to provide timely consultation and diagnostic evaluation for cardiovascular disease or stroke care.

E. Cardiovascular Disease and Stroke Telemedicine Program Approved Distant Site. Consulting specialty providers who practice within the State, the District of Columbia, or a contiguous state may be approved as consulting providers for Cardiovascular Disease and Stroke Telemedicine Program consultation services.

.08 Technical Requirements.

A. A provider of health care services delivered through telemedicine shall adopt and implement technology in a manner that supports the standard of care to deliver the required service.

B. A provider of health services delivered through telemedicine shall, at a minimum, meet the following technology requirements:

(1) A camera that has the ability to manually or under remote control provide multiple views of a patient with the capability of altering the resolution, focus, and zoom requirements according to the consultation;

(2) Audio equipment that ensures clear communication and includes echo cancellation;

(3) Bandwidth speeds sufficient to provide quality video to meet or exceed 15 frames per second;

(4) Display monitor size sufficient to support diagnostic needs used in the telemedicine services; and

(5) Create video and audio transmission with less than 300 millisecond delay.

.09 Confidentiality.

The originating and consulting providers:

A. Shall comply with the laws and regulations concerning the privacy and security of protected health information under:

(1) Health-General Article, Title 4, Subtitle 3, Annotated Code of Maryland; and

(2) The Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §§1320d et seq., as amended, the HITECH Act, 42 U.S.C. §§17932, et seq., as amended, and 45 CFR Parts 160 and 164, as amended;

B. Shall ensure that all interactive video technology-assisted communication comply with HIPAA patient privacy and security regulations at the originating site, at the distance site, and in the transmission process;

C. May not disseminate any participant images or information to other entities without the participant's consent, unless there is an emergency that prevents obtaining consent; and

D. May not store at originating and distant sites the video images or audio portion of the telemedicine service for future use.

.10 Medical Records.

A. The originating and consulting providers shall maintain documentation in the same manner as during an in-person visit or consultation, using either electronic or paper medical records.

B. Telemedicine records shall be retained according to the provisions of Health-General Article, §4-403, Annotated Code of Maryland.

C. The participant has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

.11 Limitations.

A. A service provided through telemedicine is subject to the same program restrictions, preauthorizations, limitations, and coverage that exist for the service when provided other than through telemedicine.

B. A telemedicine service does not include:

(1) An audio-only telephone conversation between a health care provider and a patient;

(2) An electronic mail message between a health care provider and a patient;

(3) A facsimile transmission between a health care provider and a patient; or

(4) A telephone conversation, electronic mail message, or facsimile transmission between the originating and consulting providers without interaction between the consulting provider and the patient.

C. "Store and Forward" technology does not meet the Maryland Medical Assistance Program's definition of telemedicine.

D. Telemedicine-delivered services may not bill to the Maryland Medical Assistance Program when technical difficulties preclude the delivery of part or all of the telemedicine session.

E. The Department may not reimburse for consultation that occurs during an ambulance transport.

F. Telemental health services are not covered under this regulation but are covered under COMAR 10.21.30.

G. The Department may not reimburse for services that require in-person evaluation or that cannot be reasonably delivered via telemedicine.

H. The Department may not reimburse consulting providers for a facility fee.

.12 Reimbursement.

A. There are two categories of fees that the Department shall reimburse an approved telemedicine provider, as applicable:

(1) Originating site facility fee; and

(2) Professional fee.

B. Originating Site Facility Fee.

(1) The originating site facility fee is set:

(a) In the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.07.02; or

(b) By the Health Services Cost Review Commission for sites located in regulated space.

(2) Originating sites shall use the appropriate telemedicine service modifier.

(3) Fees paid to the originating site may be used to pay for:

(a) Line or per minute usage charges, or both; and

(b) Any additional programmatic, administrative, clinical, or contingency support at the originating site.

C. Professional Fee.

(1) The professional fee for originating and consulting providers is set forth in the Maryland Medical Assistance Program Physicians' Services Provider Fee Manual, which is incorporated by reference in COMAR 10.09.02.07.

(2) Professional fees charged for telemedicine services shall be billed with the appropriate telemedicine service modifier.

Administrative History

Effective date: September 30, 2013 (40:19 Md. R. 1546)

Regulation .02B amended effective April 28, 2014 (41:8 Md. R. 471)

Regulation .08 amended effective April 28, 2014 (41:8 Md. R. 471)

End quoted text

Appendix R: Physician Licensing in Maryland

Maryland law requires a physician to obtain a license from the Maryland State Board of Physicians before the physician can practice medicine in the State.[201,202] There are limited exceptions to this requirement, and certain individuals may practice medicine in the State without a license.[203] The following is a summary of physician licensing in Maryland.

Telemedicine Licensing Requirements in Maryland

In 2009, Maryland adopted regulations governing the practice of telemedicine by physicians in the State. The regulations require that an individual must be licensed to practice medicine in Maryland in order to practice telemedicine if the physician seeking to practice telemedicine is either: 1) physically located in Maryland; or 2) the patient is in Maryland.[204] Under these regulations, telemedicine is defined as the practice of medicine from a distance in which intervention and treatment decisions and recommendations are based on clinical data, documents, and information transmitted through telecommunication systems.[205] The regulations specifically exclude from their scope the use of an electronic means by a treating physician licensed in Maryland who is seeking consultative services of another licensed health care practitioner with respect to an individual patient.[206] The regulations define consultative services as a service provided by a physician for the sole purpose of offering expert opinion or advising the treating physician about an individual patient, and specifically state that these services do not include decisions that direct patient care or interpretation of images, tracings, or specimens on a regular basis.[207]

The regulations define physician-patient relationship as a relationship between a physician and a patient in which there is an exchange of individual, patient specific information.[208] Before providing treatment recommendations or decisions, or prescribing medication through telemedicine, the physician is required to perform a patient evaluation adequate to establish diagnoses and identify underlying conditions or contraindications to recommended treatment options.[209] If the physician-patient relationship does not include prior in-person, face-to-face,

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[201] Md. Code Ann., Health Occupations § 14-301 (Health-Occ).
[202] To practice medicine means to engage, with or without compensation, in medical 1) diagnosis; 2) healing; 3) treatment; or 4) surgery; Health Occ. § 14-101(o)(1). The statute specifically excludes the following activities as constituting the practice of medicine: 1) selling any nonprescription drug or medicine; 2) practicing as an optician; or 3) performing a massage or other manipulation by hand, but by no other means. *Id.* at § 14-101(o)(3).
[203] The following are some examples of instances where an individual may be permitted to practice medicine in Maryland without a Maryland license: a. a medical student or individual in a post graduate training program doing assigned duties at the office of a Maryland licensed physician; b. a physician licensed by and residing in another jurisdiction, if the physician is engaged in consultation with a Maryland licensed physician about a particular patient and does not direct patient care, or if the physician licensed and residing in another jurisdiction is engaged in clinical training with a Maryland licensed physician; c. a physician employed by the federal government while performing duties incident to that employment; and d. a physician who resides in and is authorized to practice medicine by any state adjoining Maryland and whose practice extends into Maryland, if: 1) the physician does not have an office or other regularly appointed place in Maryland to meet patients; and 2) the same privileges are extended to licensed physicians of Maryland by the adjoining State.
[204] COMAR 10.32.05.03.
[205] COMAR 10.32.05.02B(8).
[206] COMAR 10.32.05.01B.
[207] COMAR 10.32.05.02B(1)(a) and (b).
[208] COMAR 10.32. 02B(6).
[209] COMAR 10.32.05.05A.

interaction with a patient, the physician must incorporate real-time auditory communications or real-time visual and auditory communications to allow a free exchange of information between the patient and the physician performing the patient evaluation.[210] The regulations define face-to-face as within each other's sight and presence.[211] The regulations define real-time to mean simultaneously or quickly enough to allow two or more individuals to conduct a conversation.[212]

The regulations do allow physicians to provide interpretive services via telemedicine without conducting a patient evaluation as described above.[213] Interpretive services are defined as official readings of images, tracings, or specimens through a telemedicine link, and specifically include remote, real-time monitoring of a patient being cared for within a health care facility.[214] While a physician can provide such services without a patient evaluation, the physician must be sure that there is no clinically significant loss of data during transmission of that data.[215]

In addition to these requirements, the regulations provide that a physician practicing telemedicine must obtain and document patient consent, create and maintain adequate medical records, follow applicable state and federal laws and regulations regarding confidentiality and disclosure of medical records.[216]

Maryland regulations also set forth specific standards for the practice of telemedicine using a website.[217] Physicians who practice telemedicine using a website to communicate with patients must disclose on the website their licensure status and Maryland physician license number, health maintenance organization, health insurer, or physician ownership of website, financial interest in the products or services advertised or offered on the site, and the privacy practices used by the physician.[218]

Physicians practicing telemedicine through a website must also establish policies relating to how the physician will verify the identification of the individual transmitting a communication, how the physician will prevent access to data by unauthorized persons, and how soon an individual can expect a response from a physician to questions or other requests included in the transmissions.[219]

Finally, the regulations require that the Maryland State Board of Physicians use the same standards in evaluating and investigating a complaint and disciplining a licensee who practices telemedicine as it would for a licensee who does not use telemedicine technology in the licensee's practice.[220]

[210] COMAR 10.32.05.05C.
[211] COMAR 10.32.05.02B(2).
[212] COMAR 10.32.05.02B(7).
[213] COMAR 10.32.05.06B.
[214] COMAR 10.32.05.02(4).
[215] COMAR 10.32.05.06C.
[216] COMAR 10.32.05.06D(4).
[217] COMAR 10.32.05.04.
[218] COMAR 10.32.05.04A(1).
[219] COMAR 10.32.05.04A(2).
[220] COMAR 10.21.05.07.

Developments in Telemedicine Guidelines since Maryland's Adoption of Telemedicine Regulations

In the spring of 2014, the Federation of State Medical Boards (FSMB)[221] and the American Medical Association (AMA) issued separate guidelines designed to assist states with regulation of the rapidly evolving practice of telemedicine. The FSMB's guidelines entitled, Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine is intended to serve as a guide for state medical boards in regulating the use of telemedicine technologies in the practice of medicine. The guidelines are also intended to educate licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies. The AMA's guidelines entitled, Coverage of and Payment for Telemedicine, provide that telemedicine services should be covered and paid for if such services adhere to their recommended standards.

FSMB's Telemedicine Guidelines

The FSMB's telemedicine guidelines state that the physician-patient relationship is fundamental to the provision of acceptable medical care. Accordingly, under their principles, a physician is discouraged from rendering medical advice and/or care using telemedicine technologies without: 1) fully verifying and authenticating the location, and to the extent possible, identifying the requesting patient; 2) disclosing and validating the practitioner's identity and applicable credentials; and 3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient.

Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish such relationship consistent with the guidelines above. A physician-patient relationship can be established using telemedicine technologies provided the standard of care is met.

The FSMB guidelines define telemedicine as the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening health care practitioner. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support health care delivery by replicating the interaction of a traditional, encounter in person between a practitioner and a patient.

Under the FSMB guidelines, a physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.

[221] The FSMB is a national nonprofit representing the 70 medical and osteopathic boards of the United States and its territories.

The FSMB guidelines also state that a documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

The AMA's Telemedicine Guidelines

Shortly after the FSMB's guidelines were issued, the AMA issued their telemedicine guidelines. Unlike the FSMB guidelines, the AMA principles do not specifically address standards for telemedicine prescribing and patient informed consent, nor do they discuss issues relating to physician financial disclosures or conflicts of interest. The AMA principles do, however, discuss medical liability insurance considerations, as well as encourage additional research and participation in pilot programs to support the case for telemedicine. The AMA's principles also provide that telemedicine services should be covered and paid for if they abide by the following principles:

a) Valid physician-patient relationship: Must be established before providing telemedicine services. Such a relationship can be established through (i) a face-to-face examination,[222] where a face-to-face- encounter would otherwise be required for providing the same services in person; (ii) consultation with another physician who has an ongoing physician-patient relationship with a patient and agrees to supervise the patient's care; or (iii) meeting standards of establishing a physician-patient relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies.

b) State licensure and scope of practice laws: Physicians and other practitioners delivering telemedicine services must abide by state licensure and scope of practice laws and requirements in the state where the patient receives services.

c) Choice of practitioner: Patients seeking care via telemedicine must have a choice of practitioner and access to the licensure and board certification qualifications of the practitioners prior to their visit. This recommendation is similar to the FSMB's recommended informed consent process.

d) Consistent standards and scope: The standards and scope of telemedicine services should be consistent with state laws.

e) Privacy and transparency: Telemedicine services must be delivered (i) consistent with state and federal laws regarding privacy and security of patients' medical information; and (ii) in a

[222] While the guidelines do not specifically define face-to-face examinations, the report on which the guidelines are based provides that the face-to-face encounter could occur in person or virtually through real-time audio and video technology. It is worth noting that the AMA had previously taken the position that a valid physician-patient relationship could be established only through an in-person consultation.

transparent manner, including physician and patient identification prior to service delivery, cost sharing responsibilities, and any limitations on drugs that can be prescribed via telemedicine.

f) Patient history and documentation: The patient's medical history must be collected as part of the provision of any telemedicine service and each telemedicine visit must be documented and include a visit summary provided to the patient.

g) Continuity of Care and emergency services: The provision of telemedicine services must include care coordination with the patient's medical home or existing treating physician, and must follow established protocols for referral for emergency services.

Possible Solution to the Barrier Posed By State-by-State Licensure Requirement

While the FSMB and AMA guidelines focus on different aspects of telemedicine, both maintain that the establishment of a valid physician-patient relationship is fundamental to the proper delivery of telemedicine services. Both sets of guidelines also clearly support the long-standing principle that the location of the patient determines where the physician must be licensed.

This historical model of state licensure has proved to be a substantial hurdle to the practice of telemedicine across state lines. Simply put, state-by-state licensing requirements limit a practitioner's ability to provide health care services across state lines. As a result, access to care is hindered, especially for patients in rural areas or those in states that do not have needed in-state specialties. It also poses a significant burden to the physician because of the time and expense of applying for multiple licenses.

There are a number of approaches to minimize the problems posed by the state-by-state licensing requirements. One such approach is an interstate compact. The U.S. Constitution grants states the ability to enter into multistate agreements, known as interstate compacts. These compacts coordinate state policy addressing particular issues, adoption of common regulatory standards, and cooperation on regional or national matters. A compact exists simultaneously as a contract between contracting states and a standalone statute within state law.

The National Council of State Boards of Nursing's Nurse Licensure Compact (NLC) is an example of a multi-state compact designed to ease the barriers to nurses holding multiple licenses across state lines. The NLC allows a nurse to have one license (in his or her state of residency) and to practice in other states (both physically and electronically), subject to each state's practice law and regulation. This compact has been in existence for over 10 years, and there are currently 24 member states, including Maryland.[223]

The FSMB has recently drafted a medical license compact that is similar to the nursing compact. Organized by the FSMB in 2013, a team of state medical board representatives and experts from the Council of State Governments developed and drafted a framework for an Interstate Medical Licensure Compact – potentially new licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the Compact. The drafting process has continued through 2014, with the most recent draft released on May 5, 2014. The FSMB anticipates that the final model legislation for the interstate medical license

[223] Four states (Illinois, Massachusetts, Minnesota, and New York) have pending NLC legislation.

compact will be ready for state legislative consideration in 2015. Under the new proposed system, participating state medical boards would retain their licensing and regulation of physicians who practice across state borders. Participation in the compact would be voluntary for both states and physicians.

The FSMB believes that support is growing among legislators and health policymakers for the compact, which the federation expects to significantly reduce barriers to the process of gaining licensure in multiple states at a time when telemedicine is growing and millions of new patients are likely to enter the U.S. healthcare system.

Appendix S: 2011 Telemedicine Task Force Recommendations

The following recommendations were identified by the 2011 Telemedicine Task Force to promote telehealth adoption in Maryland, as outlined in the report, *Telemedicine Recommendations*.[224] Since the report was published, legislation was enacted in Maryland around reimbursement for telehealth services and credentialing and privileging.[225,226]

Begin quoted text

- State-regulated payers should reimburse for telemedicine services

State-regulated payers (payers)[227] should provide reimbursement for health care services delivered through telemedicine to the same extent as health care services provided face-to-face, regardless of the location for which the services are provided.[228] Telemedicine services should be assessed to determine the appropriateness, provided that the appropriateness is determined in the same manner as it is for face-to-face services. These assessments may be conducted as part of benefit design and retrospectively through utilization review.

- Establish a centralized telemedicine network built on existing industry standards

An interoperable telemedicine network that is built on existing standards and is integrated into the state designated health information exchange would enable broad provider participation, allow networks to connect to other networks, and have access to clinical information through the exchange. Organizations that adopt telemedicine should meet certain minimum requirements related to technology and connectivity to a centralized telemedicine network.

- Implement changes in licensure, credentialing, and privileging of providers to facilitate the adoption of telemedicine

Regulations should be aligned with newly revised Center for Medicare and Medicaid Services rules that permit privileging and credentialing by proxy, a process by which an originating-site hospital may rely upon the credentialing and privileging decisions made by a distant-site telemedicine entity. As telemedicine advances in the state, additional consideration regarding expanding existing regulations to support out-of-state providers that meet certain conditions to provide telemedicine services to patients in Maryland is required. Future changes in licensure are needed to enable reciprocity of licensure for physicians practicing in border states.

End quoted text

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[224] MHCC, *Telemedicine Recommendations*, December 2011. Available at: http://mhcc.maryland.gov/mhcc/pages/hit/hit_telemedicine/documents/TLMD_TLMD_Recommend_rpt_20111201.pdf.
[225] Md. Code Ann., Insurance § 15–139. See Appendix X.
[226] Md. Code Ann., Health - General § 19–319. See Appendix X.
[227] State-regulated payers are insurers, nonprofit health services plans, or any other person that provides health benefit plans subject to regulation by the State.
[228] Self-insured health care plans and government plans are exempt from State insurance regulation under the Employee Retirement Security Act of 1974 (ERISA). State mandated health insurance benefits affect around 25 percent of insured Maryland residents. Additional information is available from the U.S. Department of Labor at: http://www.dol.gov/dol/topic/health-plans/erisa.htm.

Appendix T: Task Force Meeting Schedule

The first Telemedicine Task Force (Task Force) meeting was held on July 24, 2013 and included a joint session all three Task Force advisory groups: Clinical Advisory Group, Finance and Business Model Advisory Group, and Technology Solutions and Standards Advisory Group. Additional meetings were subsequently convened as indicated in the meeting schedule below.

2013 Joint Session

Wednesday, July 24, 10:00 a.m. - 12:00 p.m.

Clinical Advisory Group

Thursday, August 22, 1:00 p.m. - 3:00 p.m.
Monday, September 23, 10:15 a.m. - 12:15 p.m.
Thursday, October 24, 10:00 a.m. - 12:00 p.m.
Monday, November 18, 10:00 a.m. - 12:00 p.m.

Technology Solutions and Standards Advisory Group

Wednesday, August 14, 9:30 a.m. - 11:30 a.m.
Wednesday, September 11, 3:00 p.m. - 5:00 p.m.
Thursday, October 10, 10:00 a.m. - 12:00 p.m.
Tuesday, November 5, 3:00 p.m. - 5:00 p.m.

2014 Joint Session

Friday, March 7, 2:00 p.m. - 4:00 p.m.

Clinical Advisory Group

Friday, March 21, 1:30 p.m. - 2:30 p.m.
Wednesday, April 2, 1:30 p.m. - 2:30 p.m.
Monday, April 7, 1:30 p.m. - 3:30 p.m.
Friday, April 18, 1:30 p.m. - 2:30 p.m.
Wednesday, April 30, 1:30 p.m. - 2:30 p.m.
Wednesday, May 14, 1:30 p.m. - 2:30 p.m.
Monday, June 2, 1:30 p.m. - 2:30 p.m.
Monday, June 23, 1:30 p.m. - 2:30 p.m.
Tuesday, July 22, 1:30 p.m. - 2:30 p.m.

Finance and Business Model Advisory Group

Tuesday, April 29, 2:00 p.m. - 4:00 p.m.
Tuesday, June 17, 11:00 a.m. - 12:00 p.m.
Monday, July 21, 2:00 p.m. - 3:00 p.m.

Technology Solutions and Standards Advisory Group

Friday, March 14, 10:00 a.m. - 12:00 p.m.
Wednesday, April 9, 10:00 a.m. – 11:00 a.m.
Tuesday, April 22, 2:00 p.m. - 4:00 p.m.
Thursday, May 8, 2:00 p.m. - 3:00 p.m.

Appendix U: Task Force Meeting Summaries

Summaries of the Telemedicine Task Force (Task Force) meetings between July 2013 and July 2014 are included below; summaries of Task Force meetings that were held via conference call are not listed.

Telemedicine Task Force
July 24, 2013 Meeting Summary
Agenda

Initial Task Force Meeting

- The Maryland Health Care Commission (MHCC) presented the role of the Telemedicine Task Force (Task Force), reporting timeframes, deliverables, telemedicine legislative activity, and telemedicine landscape (see slide deck available online here)
- Hospitals attending the meeting reported pursuing telemedicine across a variety of use cases and specialties, though the services are generally not collaborative among various hospital systems
- Discussions among hospitals on collaborative services, particularly tele-stroke, have been underway; current reimbursement and credentialing environment has slowed progress on creating a larger tele-stroke network
- Payers have reported very low utilization of telemedicine as reflected in claims data; however, the shift away from fee-for-service billing has given provider organizations greater flexibility to consider its use as one component of practice transformation
- Medicaid continues to expand its policies for telemedicine; regulations are currently under review to expand coverage for telemedicine across approximately 10 rural counties and for cardiovascular/stroke services statewide
- The Task Force discussed how telemedicine is evolving to be less capital-intensive, such as through software-enabled technology on tablets and smartphones

Clinical Advisory Group and Finance and Business Model Advisory Group

- The Clinical Advisory Group and the Finance and Business Model Advisory Groups (groups) emphasized the need to focus on virtualized care, and use cases where there is evidence to support strong clinical outcomes; the groups also indicated that clinical quality oversight of providers rendering services should also be considered
- A consensus was formed around aligning the work of the Task Force with new federal Centers for Medicare and Medicaid Services Health Reform priorities, such as reducing hospital readmission rates
- The importance of terminology was highlighted, with a suggestion to talk about "virtualized care" rather than telemedicine because it emphasizes service delivery instead of technology; terminology should also be inclusive of services such as home health monitoring
- Patient and provider education were also discussed as an area of focus for the groups

- The groups deliberated the importance of rural and urban distinctions with regards to telemedicine in Maryland, since both geographies experience issues regarding access to care and under-utilization
- *The Clinical Advisory Group is scheduled to meet on August 22nd from 1pm – 3pm and will determine the clinical scope of services for evidence-based telemedicine where strong potential for statewide collaboration exists and identify key issues to be discussed in the interim report*
- *The Finance and Business Model Advisory Group will meet ad hoc as needed*

Technology Solutions and Standards Advisory Group

- The Technology Solutions and Standards Advisory Group (TSS advisory group) discussed the technology needed to enable widespread use of telemedicine, including scalability, scheduling, patient consent, provider availability, business case and provider directory
- The importance of interoperability was discussed; enabling patient information to be available during services delivered through telemedicine
- The TSS advisory group recognized that telemedicine is being used within health care systems and organizations; however, it is not widely used across disparate health care entities
- The TSS advisory group will outline challenges to be resolved; solutions and recommendations appropriate for both large and small health care organizations are needed
- *The TSS advisory group is scheduled to meet on August 14th from 9:30am – 11:30am and will begin considering the technical infrastructure challenges to support telemedicine that is vendor neutral and facilitates expansion*

Telemedicine Task Force

Technology Solutions and Standards Advisory Group

August 14, 2013 Meeting Summary

Key discussion items include:

- The Maryland Health Care Commission (MHCC) provided a status update and delivered a presentation on the Chesapeake Regional Information System for our Patients (CRISP) Query Portal (portal); the Technology Solutions and Standards Advisory Group (TSS advisory group) discussed the potential for including a new telemedicine tab in the portal to identify provider availability, supply, demand, and technology
- The proposed *Guiding Principles* for the TSS advisory group were reviewed; some revisions were proposed. The final version appears below:
    1) Foster patient-centered telemedicine solutions that allow for the measurement of quality and clinical outcomes
    2) Allow the marketplace to develop technology solutions with minimal State requirements, consistent with industry standards that enable interoperability, and in compliance with federal and State privacy and security laws

3) Identify technical approaches that enable telemedicine to be a component of innovative care delivery models
4) Propose telemedicine solutions that incorporate the use of health information exchange and electronic health records

- Broad consensus exists for the State to identify telemedicine solutions that meet some defined level of criteria that could be guiding to providers and beneficial for patients

The TSS advisory group is scheduled to meet on September 11th from 3:00pm – 5:00pm at MHCC and will further discuss the functionality of the proposed telemedicine tab in the portal; the tab is envisioned to include a listing and availability of providers practicing telemedicine

Telemedicine Task Force
Clinical Advisory Group
August 22, 2013 Meeting Summary

Key discussion items:

1. The Maryland Health Care Commission (MHCC) presented an overview of the Chesapeake Regional Information System for our Patients (CRISP); an update on Telemedicine Task Force Technology Solutions and Standards (TSS) Advisory Group discussion on the potential for including a telemedicine tab in the CRISP query portal to identify provider availability, supply, demand and technology; and the Guiding Principles for the TSS Advisory Group.
2. The proposed *Guiding Principles* for the Clinical Advisory Group (CAG) were reviewed and revised as follows:
    1. The CAG should look beyond telemedicine and include discussions of and recommendations for other telehealth interventions such physical therapy, speech therapy, home health monitoring, mental health, and others.
    2. While access to telehealth services in rural areas is of particular concern, the use of telehealth should be encouraged and reimbursed when best practices support improved access, improved clinical outcomes, improved health professional productivity, and cost savings regardless of the geographical location of the patient.
    3. The CAG should attempt to align its work with state and national health care priorities.
    4. Barriers to the licensing and credentialing of telehealth providers should be addressed, but should remain sufficiently robust to ensure patient safety and quality of care.
    5. Telehealth networks should be interoperable by whatever means is most feasible and cost effective.
    6. Consumers as well as health care providers should be educated on the appropriate uses and benefits of telehealth.
    7. The CAG will develop recommendations that enable synergies with the Technology Solutions and Standards as well as the Finance and Business Model Advisory Groups.
3. The task list of requirements in Senate Bill 776 for the CAG to address were expanded and prioritized by the CAG as follows:

1. Underserved population areas and strategies for telehealth deployment in rural areas to increase access to healthcare
2. Health professional productivity, resources, and shortages
3. Licensing, credentialing and regulatory oversight issues
4. Innovative service models for diverse care settings to include chronic and acute care
5. Multimedia uses of products and services for patient engagement, education and outcomes

4. Telehealth may improve access to care when there are barriers that are the result of geography, temporal or socioeconomic reasons.
5. There are emerging technology solutions for broadband access in rural areas including 3G and 4G networks.
6. The CAG would like to review the benefits of telemedicine in other states and countries, such as Virginia, Wyoming, Nebraska, Canada and Australia.
7. Concerns were raised that hospitals in Maryland may not currently have the capital to invest in the development of telehealth. Discussion ensued regarding whether the purchase of telemedicine technology could be built into reimbursement.
8. Barriers to telehealth access in Maryland were discussed including:
    1. Reimbursement
    2. The cost of research and development
    3. Technology adoption, use and interoperability
    4. Licensing/hospital credentialing
    5. Provider acceptance
    6. Lack of advocacy
    7. Resistance to develop at the originating site
    8. The lack of rurality in the state as compared to other states that have high telemedicine adoption rates

The CAG will meet on September 23, 2014 from 10am – 12pm at MIEMSS.

Telemedicine Task Force

Technology Solutions and Standards Advisory Group

September 11, 2013 Meeting Summary

Key discussion items include:

- The updated *Guiding Principles* for the Technology Solutions and Standards Advisory Group (TSS advisory group) were reviewed; feedback from the members had been incorporated
- The Maryland Health Care Commission (MHCC) presented a concept for a registry of providers in Maryland practicing telemedicine that could be made available through the State-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP), portal. The registry would:

- Enable providers to identify other providers for referrals and consultations via telemedicine; and
- Contain information on providers who participate in telemedicine, specialty, availability, and technology

- The TSS advisory group identified several considerations with regards to such a registry:
  - CRISP described the provider directory solution it is implementing to support the Maryland Health Benefits Exchange, and how it may be used to support other services such as telemedicine if there is sufficient demand from the market
  - The TSS advisory group considered whether the directory would simply present information on providers' telemedicine capabilities or if it would serve as a bridge or broker of actual telemedicine encounters; most members preferred a phased approach
  - Members encouraged the TSS advisory group to consider minimum standards for privacy and security for providers who would be listed in the registry
  - Members questioned whether the registry information could also be made available to consumers; some expressed that the value of the solution may be lessened if it were limited to providers utilizing CRISP
  - The importance of a flexible approach was emphasized such that future uses could evolve
- Members identified a preliminary list of data elements to be included in the registry and policies that need to be developed
- *The MHCC intends to explore the registry further by developing functional architecture diagrams and wireframes; these will be presented at the next TSS advisory group meeting; the TSS advisory group will continue to value-added aspects for the registry, including how to best utilize the information that the HIE system can provide.*
- *The TSS advisory group is scheduled to meet on October 10th from 10:00am – 12:00pm at MHCC and will further discuss the functionality of the proposed telemedicine tab in the portal*

Telemedicine Task Force
Clinical Advisory Group
September 23, 2013 Meeting Summary

Key discussion items:

- The Guiding Principles for the Clinical Advisory Group (CAG) were accepted as written.
- The following task list of requirements in Senate Bill 776 for the CAG to address, which were prioritized by the CAG at the last meeting, were discussed and expanded upon:
  1. *Underserved population areas and strategies for telehealth deployment in rural areas to increase access to healthcare*
     a. Expand the original survey of Rural Emergency Departments to include primary care physicians and rural health with location identifiers for telemedicine priorities.

- The Health Systems and Infrastructure Administration at DHMH conducted an informal survey in December 2012 of safety net providers across the state. The purpose of the "access to care" survey was to look at population shifts as health care reform is implemented. Data for specific disease concerns in regards to population i.e. "what services are the Medicaid or uninsured patients seeking". Ms. Walsh will provide any available data on these disease specific areas.

2. *Health professional productivity, resources, and shortages*
    a. Dr. Pruitt said organization of the health care system by specialty, such as child psychiatry, to include allied partners (psychologists, social workers, etc.) would maximize patient access to care via telehealth. There are only 7000 pediatric psychiatrists in the US.
3. Licensing, credentialing and regulatory oversight issues
    a. Licensing credentialing and regulatory oversight issues were tabled for a later discussion
4. *Innovative service models for diverse care settings to include chronic and acute care*
    a. Develop a Matrix of Public Health Priorities to include, Prevention, Acute Care, Critical Care, Primary Care, Home Care and Palliative/End of Life Care.
        - Data on Public health measures and outcomes
        - Process measures to improve access to the appropriate medical specialists
        - Review published and unpublished program usage of telemedicine/telehealth for individual disease processes
        - Develop base model for telemedicine/telehealth that allows for future scope expansion for improved health status and health outcomes to include:
            - Major disparities in access to care: Behavioral Health, Maternal/Child Health
            - Hospital readmission diseases: Diabetes, CHF and COPD/Asthma
            - Cause of death: Heart Disease, Cancer, Stroke and Trauma
5. Multimedia uses of products and services for patient engagement, education and outcomes
    a. Dr. Reynolds said one of the recommendations to the general assembly should be the development of a telemedicine program for medical school and ancillary school curriculums.

Dr. Bass said that focusing on a specific list of diseases to start is not intended to limit the future uses of telemedicine/telehealth but to use as a basis for recommendations. This list could be reduced or expanded to what is feasible in the time frame required. The Clinical Advisory Group is building the foundation for our "ask" to the general assembly to improve health status and health outcomes through telehealth.

Delegate Lee stressed the importance and urgency in producing a document to include recommendations with evidence of cost savings that can overcome the current obstacles to telemedicine within the state.

The CAG will develop a "Drop Box" with the matrix for sharing of documents and supporting evidence.

Michelle Clark reported that the FCC has a funding opportunity to connect facilities with broadband services and network equipment. Healthcare facilities need to apply as a consortium and need to be majority rural. Michelle will reach out to Garrett Memorial and McCready hospitals.

Telemedicine Task Force

Technology Solutions and Standards Advisory Group

October 10, 2013 Meeting Summary

Key discussion items include:

- The Maryland Health Care Commission (MHCC) presented draft wireframes for a telemedicine provider directory (directory) that would be made available through the State-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP)
- The group discussed how the directory could be implemented in a phased approach, allowing for improvements and changes to the system over time
- Initially, the directory would:
    - House a registry of telemedicine providers detailing provider information including specialty, availability, services offered, technology capabilities, etc.;
    - Create a source of information for providers to incorporate into existing workflows; and
    - Support various clinical uses by facilitating real-time connections among providers in emergency and non-emergency situations, in addition to allowing informational browsing for routine/elective services.
- TSS advisory group members proposed several additional features to evaluate and consider for the directory:
    - Pre-login capabilities to allow registered and non-registered CRISP users to review preliminary information about providers offering telemedicine services, which may further enable interest and adoption of the registry and telemedicine in general;
    - The inclusion of information on group practices as a whole, in addition to individual provider information;
    - Exchange of payment data from hospitals and/or payers in addition to data that already exists within CRISP, to make the resource more valuable to telemedicine practitioners; and

- Educational information and links to resources that are useful for those providers interested in considering telemedicine options and adopting innovative care models.

The MHCC will continue to explore various options for the directory by incorporating feedback received from TSS advisory group members on the architecture diagrams and wireframes. The TSS advisory group will continue evaluating value-added aspects for the directory as well as determine user access criteria and authentication processes.

The next TSS advisory group meeting is scheduled on November 5th from 3:00 p.m. – 5:00 p.m. at MHCC. Members will review a second draft of the proposed wireframes and continue to evaluate various features for the directory.

Telemedicine Task Force
Clinical Advisory Group
October 24, 2013 Meeting Summary

Key discussion items:

1. Sarah Orth gave an overview of the list of other statewide telemedicine networks compiled by MHCC and placed in the Telemedicine Clinical Advisory Group (CAG) Dropbox. (Links to each program are available for more information)
    a. Most programs had federal or state funding to initiate programs; mostly in rural areas
    b. Some programs have already closed possibly due to having initial funding but no funding for ongoing programs or a sustainable business model.
    c. Private insurers have supported individual telemedicine programs but only within their networks
2. Recommend that the Maryland General Assembly fund a lead agency/entity to develop an infrastructure and sustainable business model for interoperable Telehealth in the State.
    a. Funding would likely be needed to stand up the lead agency/entity which would
        i. Seek grants
        ii. Develop directories
        iii. Create a self-sustainable business model
            1. Consider a consortium of hospitals to assist with funding the infrastructure
            2. Insurers would need to participate in the business model
        iv. Provide educational outreach to both healthcare providers and the public
    b. It was suggested that MHCC and CRISP be considered for this lead
3. Establish a subcommittee to research barriers to Telemedicine/Telehealth licensing and credentialing.
    a. Include members from MedChi, the Maryland Hospital Association, and the State Licensing Boards

b. The CAG group suggested a small environmental scan might be useful to identify what, if any, barriers to telemedicine adoption/acceleration related to licensing might exist in Maryland.

c. In 2012, the Federation of State Medical Boards released an overview of telemedicine licensure across the US (www.fsmb.org/pdf/grpol_telemedicine_licensure.pdf)

d. Virginia Rowthorn, will chair the subcommittee. The following persons have volunteered to serve on the subcommittee:

   i) Kristen Neville, Legislation and Regulations Specialist of the Health Occupation Boards; kristen.neville@maryland.gov

   ii) Mark Woodard, Health Policy Analyst II, Maryland Board of Physicians; mark.woodard@maryland.gov

   iii) Robert Roca, Sheppard Pratt and Maryland Board of Physicians rroca@sheppardpratt.org

Telemedicine Task Force

Technology Solutions and Standards Advisory Group

November 5, 2013 Meeting Summary

Key discussion items include:

- After receiving virtual feedback from members of the Technology Solutions and Standards Advisory Group (TSS advisory group) on the wireframes for a telemedicine directory (directory), the Maryland Health Care Commission (MHCC) incorporated suggestions and presented a second draft during the meeting. The directory:
  - Would include information about providers using telemedicine in their practices; providers could learn about who is engaged in telemedicine and make connections with other providers for referrals and/or consultations.
  - Is intended to be made available via the State-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP).
- While TSS advisory group members discussed the possibility of developing a robust infrastructure for the directory to allow for interoperability between providers through telemedicine hosting services, the general consensus is to initially focus on establishing a platform for the directory to allow providers to obtain information about available telemedicine services.
- Members discussed the importance of enabling easy and immediate access for providers, including making the directory available in the form of an application for mobile devices and establishing a single sign-on process so providers could directly access the directory from their electronic health record systems.
- Members identified several policy topics for discussion, including:

- The need for a process to validate a provider's clinical credentials to enable trust among providers using the directory as a resource, which would be essential in cases of "on-demand" consults. This could be addressed by adding elements of telemedicine use in CRISP's provider agreement.
- A specific feature available in cases of emergency should clearly establish the appropriate circumstances and timeframes for providers to utilize such an option.
- Providers' technology capabilities must be known, validated and updated in the directory as necessary. In addition, testing procedures should be established to ensure compatibility among providers, including the issuance of early notifications to indicate a telemedicine encounter may not be possible.

- *In 2014, MHCC and TSS advisory group members will continue exploring value-added concepts for the directory and work towards finalizing the directory's specifications, including the architectural diagrams and wireframes. Activities will also include identifying policies for the directory.*
- *A tentative schedule for early 2014 TSS advisory group meetings has been planned as noted below:*
  - *Tuesday, January 28, 2014 3:00pm – 5:00pm*
  - *Wednesday, March 12, 2014, 3:00pm – 5:00pm*
  - *Tuesday, April 22, 2014, 3:00pm – 5:00pm*

Telemedicine Task Force

March 7, 2014 Meeting Summary

Task Force Meeting - *Agenda*

- The Maryland Health Care Commission (MHCC) presented a summary of the 2013 Telemedicine Task Force (Task Force) activities and provided an overview of key discussion items for 2014, which are intended to guide the development of Task Force recommendations;
  - A panelist introduced the discussion items for each of the three Task Force advisory groups: Clinical Advisory Group, Finance and Business Model Advisory Group, and Technology Solutions and Standards Advisory Group (see slide deck available online here)
- Task Force recommendations on telehealth expansion in Maryland will be included in a legislative report due to the Governor, Senate Finance Committee, and House Health and Government Operations Committee on December 1, 2014, as required by Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*
  - In 2014, the Task Force expects to focus on developing strategies for telehealth diffusion in innovative care delivery models, identifying innovative telehealth use cases that could be regionally deployed, and finalizing the architecture for a directory of telehealth providers to be made available through the State-Designated health information exchange (HIE)

- The Task Force discussed options to broaden the definition of telemedicine, which is currently defined in law as: *the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient.*[229]
    - A broader definition could reference "telehealth" rather than telemedicine to encompass various types of health care professionals and treatments rendered through evolving technologies and applications for telehealth; Task Force members discussed the following factors related to a broader definition:
        - Telehealth is a form service delivery that is already occurring, not a new area of practice; the definition should be broad enough to encompass existing telehealth uses as well as potential new applications
        - Telehealth adoption should not be limited by current legislation
        - Participatory and integrated care should be emphasized
        - Focus on clients, families, and caregivers; patient is technically located in the hospital, better to focus on client in the community
        - The definition should take into consideration that technology is evolving, and not stifle innovation
- The Task Force meeting concluded and subsequently the advisory groups met

Clinical Advisory Group and Finance and Business Model Advisory Group - Agenda

- The Clinical Advisory Group and the Finance and Business Model Advisory Group (advisory groups) reviewed the discussion topics for 2014 (see list of discussion topics available online here)
- Members identified key factors for consideration in identifying innovative telehealth use cases:
    - Assess in conjunction with existing telehealth applications
    - Identified based on their potential to have the greatest impact on health outcomes (e.g. medication reconciliation is one of the biggest challenges in hospitals during admission and following a patient's discharge)
    - Align with public health goals
    - Focus on high risk and vulnerable patient populations and allow additional patient population categories to be assessed over time
    - Promote existing telehealth technologies that are established and proven to be effective, keeping in mind that such technologies are constantly evolving
    - Target innovative care delivery and payment models that do not stifle innovation for future telehealth applications
    - Align with new payment reform systems that promote innovative approaches to care delivery by encouraging greater collaboration between hospitals and physicians to improve patient care to ensure sustainability

[229] Md. Code Ann., Health - General § 19–319.

- In 2014, the Clinical Advisory Group will continue exploring which use cases should be diffused in hospital population-based care delivery models to improve care transitions as well as other innovative care delivery models, such as Patient Centered Medical Homes
- The Finance and Business Model Advisory Group will begin meeting independently in April to identify finance and business opportunities that support the recommendations of the Clinical Advisory Group and the Technology Solutions and Standards (TSS) Advisory Group
- *The Clinical Advisory Group is scheduled to meet on Monday, April 7, 2014 from 1:30pm – 3:30pm at MIEMSS, Room 212*
- *Workgroup conference calls of the Clinical Advisory Group will occur on Friday, March 21, 2014 (1:30pm - 2:30pm; dial 866-247-6034; conference code: 6912847711#) and on Wednesday, April 2, 2014 (1:30pm – 2:30pm; dial 866-247-6034; conference code: 6912847711#)*
- *The Finance and Business Model Advisory Group is scheduled to meet on Tuesday, April 29, 2014 from 2:00pm – 4:00pm at MHCC*

Technology Solutions and Standards Advisory Group - *Agenda*

- Members discussed establishing an online directory of telehealth providers
    - The directory was initially proposed to be available through the State-Designated HIE, the Chesapeake Regional Information System for our Patients (CRISP)
    - Members explored the possibility of exposing the directory through the Maryland Health Connection website, which has a provider directory currently managed by CRISP (see the Maryland Health Connection provider directory here)
        - The Maryland Health Connection provider directory includes information submitted by participating health insurance companies
        - The provider directory could be updated to indicate which providers are delivering telehealth services; health insurance companies could potentially feed the telehealth information to the directory
- Considerations for additional functionality that could be used in the telehealth provider directory were also discussed
    - Information about a provider's telehealth capabilities would be important to list in the directory, including technology specifications (e.g. what technology the provider uses) and clinical services offered (e.g. mental health consultation, reading an echocardiogram)
    - An online availability feature indicated by a green button could be helpful to see which providers are available in real time for a telehealth consult
        - Members noted the reliability of such a feature may be an issue if a provider is away from the computer while listed as being online
        - The application of an online availability feature would be dependent on the use case (e.g. it may not be appropriate for emergency situations, such as stroke)
        - Protocol to govern an online availability feature would be needed

- *The TSS Advisory Group is scheduled to meet on Tuesday, April 22, 2014 from 2:00pm – 4:00pm at MHCC*
- *A workgroup conference call of the TSS Advisory Group is scheduled for Wednesday, April 9, 2014 (10:00am - 11:00am; call-in information forthcoming)*

Telemedicine Task Force
Technology Solutions and Standards Advisory Group
March 14, 2014 Meeting Summary

Key discussion items:

- The Technology Solutions and Standards Advisory Group (TSS advisory group) explored the development of a telehealth provider directory that could be made available through the State-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP)
    - CRISP provided an overview of their current provider directory, which is available through the Maryland Health Connection website (see the provider directory here)
        - The existing provider directory includes information about health care providers, including name, specialty, supported carriers and plans, address, and phone number
        - Health insurance companies participating with the Maryland Health Connection currently collect the information from providers and submit to CRISP for inclusion in the provider directory; health insurance companies could potentially request that providers indicate whether or not they are engaged in telehealth services
        - Additional information — such as telehealth technologies being used, clinical services provided, and availability for scheduling — may need to be collected through an alternate means
        - CRISP could add an annotation section in a provider profile that could potentially append the additional telehealth information
        - The provider directory is currently searchable, and telehealth could potentially be added to the search function; the ability to search by physician group may also be a possibility
    - The value of a central provider directory was discussed to enable providers and consumers to access provider information in one location
        - Exposing the telehealth provider directory through existing resources, such as CRISP and the Maryland Health Connection, could help in streamlining access to provider information
        - The possibility of linking the telehealth provider directory to other resources, such as the Mid-Atlantic Telehealth Resource Center (MATRC), was also raised; MATRC has a telehealth directory which includes telehealth providers who may be located in Pennsylvania; Delaware; Maryland;

Washington, DC; Virginia; West Virginia; North Carolina; and Kentucky (see MATRIC telehealth provider directory here)

- The importance of focusing on the State level and driving traffic to the CRISP HIE was emphasized as a consideration in developing the telehealth provider directory

- Additional policy considerations that will need to be addressed include authentication and credentialing processes, as well as maintenance to ensure the information in the telehealth provider directory is up-to-date
- The Maryland Health Care Commission (MHCC) will revise the telehealth provider directory wireframes to be aligned with the current CRISP provider directory; the revised wireframes will be shared at the next meeting of the TSS advisory group

- TSS advisory group members reviewed the definition of telemedicine to more broadly encompass telehealth services, health care professionals, and evolving technologies
  - Telemedicine is currently defined in law as: *the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient*[230]
  - TSS advisory group members developed the following working definition for telehealth: *telehealth is the delivery of health-related services and education using telecommunications and related technologies under the oversight of health care professionals*
  - TSS advisory group members discussed a number of considerations in the development of the proposed working definition:
    - Ensuring oversight of health care professionals in the provision of telehealth services
    - Acknowledging that delivery of telehealth services may not always improve health status and may be used for maintenance or end of life care
    - Ensuring the definition is broad enough to include remote monitoring and mhealth applications
  - The proposed working definition for telehealth will be shared with the Clinical Advisory Group and the Finance and Business Model Advisory Group at their upcoming meetings to gather their input; the working definition will be revised based on their feedback
- *The MHCC will hold workgroup conference calls in between in-person meetings. The first TSS workgroup conference call is scheduled for Wednesday, April 9, 2014 (10:00am - 11:00am; call-in information forthcoming)*
- *The next in-person meeting of the TSS advisory group is scheduled for Tuesday, April 22, 2014 (2:00pm – 4:00pm at MHCC)*

[230] Md. Code Ann., Health - General § 19–319.

Telemedicine Task Force

Clinical Advisory Group

April 7, 2014 Meeting Summary

Key discussion items:

- The Clinical Advisory Group reviewed the current draft telehealth definition
    - Telemedicine is currently defined in law as: *the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient*[231]
    - The current proposed draft definition for telehealth is: *the delivery of health related education and services using telecommunications and related technologies in coordination with a health care professional*
    - Clinical Advisory Group members expressed their support of the draft telehealth definition; regulations to provide further details would be developed if the new telehealth definition is enacted in law; additionally, the final legislative report could include narrative with additional details regarding the scope of telehealth[232]
- Clinical Advisory Group expects to make recommendations regarding a set of use cases for inclusion in new models of care delivery, supported by existing technology facilitated by a provider directory
    - The use cases will focus on aligning telehealth with public health goals, impacting patient health outcomes by pairing provider resources with appropriate use cases, to increase access to care
    - The use cases could be incorporated into new models of care delivery in accordance with the Affordable Care Act
    - The use cases will be implementable, testable, and cost-effective (see Clinical Advisory Group scope of work here for additional details regarding the use cases)
- Members discussed innovative telehealth use cases that and that would:
    - Use case #1: Improve transitions of care between acute and post acute settings through telehealth
        - The Maryland Health Care Commission (MHCC) is developing a pilot program for use case #1 to be implemented in late spring/early summer 2014; a bid board notice will be posted for $25K with a requirement for matching funds; responses to the bid board will be evaluated by a review panel that may include Clinical Advisory Group members; measureable results of the pilot would be assessed at the end of the summer for inclusion in the legislative report
        - The impact of mental health on other health conditions was discussed; psychiatric services could be provided to long term care (LTC) patients

[231] Md. Code Ann., Health - General § 19–319

[232] A legislative report on Task Force recommendations for telehealth expansion is due to the Governor, Senate Finance Committee, and House Health and Government Operations Committee on December 1, 2014, as required by Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*

through telehealth, especially during overnight shifts; the importance of coordinating with a provider in developing a telepsychiatry model was raised
        - Legislative report could specify examples of where telehealth could be useful, e.g. acute care hospital, nursing home, subacute care, long term acute care, etc.
    - Use case #2: Use telehealth to manage hospital Prevention Quality Indicators (PQIs), prioritizing diabetes management, hypertension, congestive heart failure, and chronic obstructive pulmonary disease as well as asthma
        - The focus of use case #2 is on high volume diseases and co-morbidities
        - Audio/visual technology could be used at the facility, and remote monitoring could be used for patients at home to monitor glucose, blood pressure, weight, peak expiratory flow, etc.
        - The possibility of developing clinical guidelines on when telehealth should be used was discussed (e.g. patients that use home oxygen would have a peak expiratory flow meter for remote monitoring)
        - Patients with most frequent hospital readmissions usually have one the four PQIs being considered for telehealth
        - Use case #2 would prioritize the four PQIs for telehealth, although would not be limited to the four PQIs, as other conditions may be relevant
    - Use case #3: Incorporate telehealth in hospital innovative payment and service delivery models through ambulatory practice shared savings programs
        - The importance of a primary care nucleus was discussed that could include internal medicine, family medicine, geriatricians, pediatricians, obstetrics, and general surgery
        - Emphasis of use case #3 is on ensuring telehealth is financed through hospital innovative payment and service delivery models
        - Difference between use case #3 and use case #4 was discussed; use case #3 is focused on hospitals, while use case #4 is focused on payors and implementing patient centered medical home (PCMH) programs
        - Applications for use case #3 could include using telehealth in emergency departments (EDs) to access stroke specialists; could also be useful in EDs for plastic surgery or ear, nose, and throat conditions where specialists may be needed and images are useful
        - Telehealth could be used by LTC facilities to access ED physicians (e.g. for dermatology, diabetes, and wound care) and to communicate with ED physicians during emergencies before residents are placed in an ambulance
    - Use case #4 (updated based on feedback from Clinical Advisory Group members): Require payor-based medical home programs to factor in reimbursement for telehealth by primary care providers and specialists

- Primary care nucleus would have overall responsibility to manage care
- Importance of having telehealth capabilities within PCMH programs was emphasized
- Clinical Advisory Group members explored how best to incorporate telehealth in payor-based medical home programs; the following options were considered: telehealth use as a core requirement, removing barriers to telehealth by requiring payors to allow telehealth use, requiring that practices demonstrate their telehealth capabilities
- Clinical Advisory Group members agreed on the following requirement for use case #4: payor-based medical home programs would be required to factor in reimbursement for telehealth by primary care providers and specialists
- Incorporating telehealth education into medical and residency training was also raised as a way to expand telehealth adoption in the State

- MHCC will update the Clinical Advisory Group scope of work and use cases based on the input received during the meeting
- *Workgroup conference calls of the Clinical Advisory Group to prioritize and develop the future telehealth use cases and explore adding clinical measures for each use case are scheduled for Friday, April 18, 2014 (1:30pm - 2:30pm; dial 866-247-6034; conference code: 6912847711#) and on Wednesday, April 30, 2014 (1:30pm – 2:30pm; dial 866-247-6034; conference code: 6912847711#)*
- *The next in-person meeting of the Clinical Advisory Group is scheduled for Monday, May 5, 2014 from 1:30pm – 3:30pm at MIEMSS, Room 212*

Telemedicine Task Force

Technology Solutions and Standards Advisory Group

April 22, 2014 Meeting Summary

Key discussion items:

- The Technology Solutions and Standards Advisory Group (TSS advisory group) reviewed wireframes for a proposed web-based telehealth provider directory; the wireframes provide a website blueprint illustrating the visual and functional framework for the proposed directory
- The telehealth provider directory would be made available based on the existing Maryland provider directory, which is currently supported by the State-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP), through the Maryland Health Connection (see the existing CRISP provider directory here)
    - The existing CRISP provider directory includes information about health care providers submitted by health insurance companies participating with the Maryland Health Connection

    - Provider name, specialty, supported carriers and plans, address, and phone number are included in the existing CRISP provider directory
- Providers who are delivering health care services through telehealth could be highlighted on the existing provider directory; providers who are not participating with a health insurance company should also be included in the directory if possible
    - The telehealth provider directory would be accessible to both providers and consumers
    - Telehealth providers could indicate their specialty and types of telehealth services they provide: urgent consultation, scheduled consultation, store and forward, image review, clinical review; providers could also indicate the telehealth technology they are using, especially for real-time audio/video conferencing
        - The value of having providers indicate whether they provide any type of emergency telehealth services was discussed; Task Force members agreed that an urgent or immediate consultation would be more appropriate as the telehealth provider directory is not intended to be a resource for emergency telehealth consultations, such as stroke; a disclaimer about emergency consultations would also need to be included on the website
        - Some concern was raised about enabling providers to select their telehealth specialty, which may not be consistent with the specialty for which they are credentialed by the payor; Task Force members noted that a provider's specialty as credentialed may vary between payors, and the existing CRISP provider directory does not list provider specialty according to payor
    - Telehealth providers could indicate their preferred method of being contacted by other providers: online chat, email, or phone
    - Task Force members discussed challenges around some of the proposed functionality, such as an online availability feature indicated by a green button and chat functionality
        - An online indicator would not be effective if providers are displayed as being available when they may in fact be away from their computers; similarly the chat functionality would only be effective if providers are at their computers
    - Task Force members also discussed the possibility of including the following types of information and functionality in the telehealth provider directory
        - Engagement in other types of telehealth services, such as community outreach or health education (e.g. for diabetes management, substance abuse)
        - Provider's scheduling availability for telehealth services
        - Provider's photo and bio, which would be especially important for consumers
        - An interactive audio/video feature similar to FaceTime or Google Hangout to enable a virtual meeting/introduction between providers; although may not be provided through the telehealth provider directory

- A section with additional information on telehealth, including relevant terminology and definitions, as well as frequently ask questions; information on how telehealth could benefit the patient would be helpful to engage consumers
- Online consultations for consumers, including scheduling and insurance verification, as consumers would likely be interested in using the telehealth provider directory to access telehealth services; the telehealth provider directory could include a link to the provider's website for accessing a telehealth consultation

Next steps

- *The Maryland Health Care Commission (MHCC) will revise the telehealth provider directory wireframes based on the feedback received during the meeting and will send the wireframes to the TSS advisory group for any additional comments*
- *The TSS advisory group will finalize the wireframes and discuss relevant policy questions at upcoming meetings:*
  - *TSS workgroup conference call: Thursday, May 8, 2014 (2:00pm – 3:00pm; https://www1.gotomeeting.com/join/338046977; dial: 866-247-6034; conference code: 6912847711#)*
  - *TSS in-person meeting: Wednesday, June 4, 2014 (2:00pm – 4:00pm at MHCC)*

Telemedicine Task Force
Finance and Business Model Advisory Group
April 29, 2014 Meeting Summary

Key discussion items:

- The Maryland Health Care Commission (MHCC) provided an overview on the role of the Telemedicine Task Force Advisory Groups in developing recommendations for telehealth diffusion in Maryland; the recommendations will be included in a legislative report due to the Governor, Senate Finance Committee, and House Health and Government Operations Committee on December 1, 2014, as required by Senate Bill 776 (2013), *Telemedicine Task Force – Maryland Health Care Commission*
- The Finance and Business Model Advisory Group reviewed a revised draft definition for telehealth that will be proposed in the legislative report
  - The revised draft definition was developed based on discussions during the initial 2014 Telemedicine Task Force meeting and subsequent advisory group meetings
  - The revised draft definition is intended to broaden the scope of telehealth to include a wide range of telehealth technologies and applications and a variety of health care professionals

    - Telemedicine is currently defined in law as: *the use of interactive audio, video, or other telecommunications or electronic technology by a physician in the practice of medicine outside the physical presence of the patient*[233]
    - The revised draft definition for telehealth is: *the delivery of health education and services using telecommunications and related technologies in coordination with a health care professional*
    - Finance and Business Model Advisory Group members (members) discussed how the revised draft definition would be applied and the financial impact, especially in terms of reimbursement
- The MHCC presented innovative telehealth use cases developed by the Clinical Advisory Group that could be incorporated in new models of care delivery (the table of use cases is available here)
- Members reviewed use case #1, *improve transitions of care between acute and post acute settings through telehealth*, which aims to reduce unnecessary hospital admissions
- Members identified the following financial and business model challenges when considering incorporating the use of telehealth into non-fee-for-service payment structures:
    - There is uncertainty of payment structure and impacts of health care reform, including the hospital waiver
        - Incentivizing hospitals to share their savings, especially when the savings may not be realized may be difficult
        - There is a need to explore how shared savings would best be allocated
        - Most physicians still practice within the fee-for-service model, and are likely to do so in the near future
    - Funding and scheduling a health care provider to be available at the hospital for consultations
    - Reimbursement methodology (i.e. how are services billed in innovative payment models? Current fee-for-service CPT and ICD-9 codes will not work)
    - Risk management and liability issues
    - Technology investment
        - Upfront costs of hardware and software to deploy the infrastructure for the telehealth program, as well as ongoing maintenance
        - Long term care (LTC) facilities may be less technologically advanced than other health care entities and less equipped to initiate telehealth programs
- Members identified the following options for consideration when developing payment structures for incorporating the use of telehealth into non-fee-for-service payment structures:
    - Shared savings programs among hospitals, LTC facilities, and ambulatory physician practices

[233] Md. Code Ann., Health - General § 19–319

        - Hospitals could incentivize LTC facilities to reduce hospital admissions by partnering in a shared savings program
        - Telehealth could be used in cases where a physician is not available on-site
        - Identify needs that could best be addressed through telehealth, e.g. psychiatry, general medicine, dermatology
    - LTC facilities could join at-risk financial payment models; important that risk and reward are matched in business model
    - Providers could be incentivized to be on call to provide telehealth services; purchasing blocks of time
        - Purchasing blocks of time for specialties, such as dermatology and psychiatry, where scheduled visits occur, as well as in an emergency room setting where visits are not prescheduled
        - Payors could explore feasibility of purchasing block time; need to consider context of payment model, e.g. telehealth has been most effective in fully capitated models or online telehealth services directed at consumers
    - Would be informative to compare how services are currently delivered in the LTC setting, including transportation costs, with how similar services would be delivered using telehealth
        - Moving a patient with dementia or Alzheimer's can lead to additional complications; LTC facility staff may accompany the patient to the hospital; hospitals may have a nurse practitioner visit an LTC facility once a week
        - Health systems or hospitals may be interested in working with LTC facilities to provide them with telehealth technology and staff training; in many cases, current technologies can be adjusted for telehealth, e.g. cell phones, tablets

Next steps:

- *The MHCC will revise the table of innovative telehealth use cases financial and business model challenges and potential solutions based on the feedback received during the meeting; much of the feedback would apply to more than one use case*
- *The Finance and Business Model Advisory Group will continue to discuss business models for the innovative telehealth use cases at upcoming meetings:*
    - *Virtual meetings*
        - *Tuesday, June 17, 2014 from 11:00am – 12:00pm (dial: 866-247-6034; conference code: 6912847711#)*
        - *Wednesday, July 9, 2014 from 10:00am – 11:00am (dial: 866-247-6034; conference code: 6912847711#)*
    - *In-person meeting on Monday, July 21, 2014 from 2:00pm – 4:00pm at MHCC*

Appendix V: Message from H. Neal Reynolds

The following is a message from H. Neal Reynolds, M.D., Chair of the Clinical Advisory Group.

Dear Telemedicine Task Force Members,

As Chair of the Clinical Advisory Group of the Telemedicine Task Force (task force), I would like to thank all those that participated in the Clinical Advisory Group; Finance and Business Advisory Group; and Technology Solutions and Standards Advisory Group. Your hard work has enabled MHCC to develop the draft report consistent with its legislative requirement, and representative of what is needed to use telehealth to improve health status and care delivery in the State.

I have reviewed the draft report and I believe MHCC has appropriately presented the recommendations from the advisory groups in a thoughtful way. Throughout this process, I was struck by the thorough deliberations of the advisory groups where recommendations were developed largely through a consensus driven process. I am excited about the draft report and hope after reading it you will share in my enthusiasm.

Sincerely, H. Neal Reynolds

H. Neal Reynolds, M.D.
Associate Professor of Medicine
University of Maryland School of Medicine
Co-Director, Multi-Trauma Intensive Care Unit at the R. Adams Cowley Shock Trauma Center

Appendix W: Advisory Group Discussion Topics

Senate Bill 776, *Telemedicine Task Force – Maryland Health Care Commission* (SB 776) outlined requirements for the 2014 Telemedicine Task Force (Task Force) to study the use of telehealth. The below topics of discussion were assigned to the Task Force advisory groups to achieve the requirements of SB 776.

Advisory Group Discussion Topics		
Clinical Advisory Group	**Finance and Business Model Advisory Group**	**Technology Solutions and Standards Advisory Group**
The role of telemedicine in advanced primary care delivery models; innovative service models for diverse care settings	Identify strategies for telehealth deployment to meet any increased demand for health care due to the implementation of the Patient Protection and Affordable Care Act	Emerging technology and standards for security
Use cases for evaluation	Innovative payment models	Identify strategies for telehealth deployment in rural areas to increase access to health care
Patient engagement, education and goals	Public and private grant funding	Supportive uses of electronic health records and health information exchange
Health professional productivity, resources and shortages; underserved population areas	Applications for cost-effective telehealth	

Appendix X: Maryland's All-Payor Hospital System Modernization

The Centers for Medicare & Medicaid Services provides an overview of Maryland's new All-Payor Hospital System Modernization. Additional information is available at: innovation.cms.gov/initiatives/Maryland-All-Payer-Model.

Begin quoted text

Maryland All-Payer Model

The Centers for Medicare & Medicaid Services (CMS) and the state of Maryland are partnering to modernize Maryland's unique all-payer rate-setting system for hospital services that will improve patients' health and reduce costs. This initiative will update Maryland's 36-year-old Medicare waiver to allow the state to adopt new policies that reduce per capita hospital expenditures and improve health outcomes as encouraged by the Affordable Care Act.

Background

Maryland operates the nation's only all-payer hospital rate regulation system. This system is made possible, in part, by a 36-year-old Medicare waiver (codified in Section 1814(b) of the Social Security Act) that exempts Maryland from the Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) and allows Maryland to set rates for these services. Under the waiver, all third parties pay the same rate. The State of Maryland and CMS expect that the All-Payer Model will be successful in improving the quality of care and reducing program expenditures for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries. Moreover, the Maryland system may serve as a model for other states interested in developing all-payer payment systems.

Initiative Details

Maryland's all-payer rate setting system for hospital services presents an opportunity for Maryland and CMS to test whether an all-payer system for hospital payment that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health and reduced costs. Under the new model, Maryland hospitals will commit to achieving significant quality improvements, including reductions in Maryland hospitals' 30-day hospital readmissions rate and hospital acquired conditions rate. Maryland will limit all-payer per capita hospital growth, including inpatient and outpatient care, to 3.58 percent. Maryland will also limit annual Medicare per capita hospital cost growth to a rate lower than the national annual per capita growth rate per year for 2015-2018. Moreover, the Maryland system may serve as a model for other states interested in developing all-payer payment systems. Under this model, Medicare is estimated to save at least $330 million over the next five years. This opportunity is available through the authority of the Innovation Center, which was created by the Affordable Care Act to test to payment and service delivery models.

Under the terms of the Maryland All-Payer Model:

- Maryland will agree to permanently shift away from its current statutory waiver, which is based on Medicare payment per inpatient admission, in exchange for the new Innovation Center model based on Medicare per capita total hospital cost growth.

- This model will require Maryland to generate $330 million in Medicare savings over a five year performance period, measured by comparing Maryland's Medicare per capita total hospital cost growth to the national Medicare per capita total hospital cost growth.
- This model will require Maryland to limit its annual all-payer per capita total hospital cost growth to 3.58%, the 10-year compound annual growth rate in per capita gross state product.
- Maryland will shift virtually all of its hospital revenue over the five year performance period into global payment models.
- Maryland will achieve a number of quality targets designed to promote better care, better health and lower costs. Under the model, the quality of care for Maryland residents, including Medicare, Medicaid, and CHIP beneficiaries will improve as measured by hospital quality and population health measures.
    - **Readmissions:** Maryland will commit to reducing its aggregate Medicare 30-day unadjusted all-cause, all-site hospital readmission rate in Maryland to the national Medicare 30-day unadjusted all-cause, all-site readmissions rate over five years.
    - **Hospital Acquired Conditions:** Maryland currently operates a program that measures 3M's 65 Potentially Preventable Conditions. Under this model, Maryland will achieve an annual aggregate reduction of 6.89% in the 65 PPCs over five years for a cumulative reduction of 30%.
    - **Population Health:** Maryland will submit an annual report demonstrating its performance along various population health measures.
- If Maryland fails during the five-year performance period of the model, Maryland hospitals will transition over two years to the national Medicare payment systems.
- Before the start of the fourth year of the model, Maryland will develop a proposal for a new model based on a Medicare total per capita cost of care test to begin no later than after the end of the five year performance period.

End quoted text

Appendix Y: Telehealth Use Case Clinical Applications and Implementation Considerations

The 2014 Telemedicine Task Force Clinical Advisory Group identified the following clinical applications for the telehealth use cases, as well as considerations that implementing organizations will need to address when deploying the telehealth use cases.

Clinical Advisory Group Telehealth Use Case Clinical Applications and Implementation Considerations	
Clinical Applications	**Implementation Considerations**
• Assessment of disposition of patient on site • Scheduling a health care practitioner to be available for consultations • Ensure patients are using the appropriate remote- and self-monitoring technology • Disease surveillance and program quality monitoring • Preventative care and early screenings (i.e. oral health, vision, allergies, etc.) • Expert support or supervision by clinicians for the management of complex cases or development of new skill sets	• Identify appropriate clinical applications for technology devices • Care practitioner networks for real-time availability, such as stroke, pediatric and obstetrical emergencies • Inconsistencies of wired and wireless connectivity, including latency, dropouts, or complete loss of connectivity in certain geographic regions of Maryland • Access to images and other relevant clinical information • Ensuring telehealth services are reimbursable (such as remote radiology report reading, etc.) • Identify investment opportunities in infrastructure development • Coordinate and collaborate with existing programs while avoiding unnecessary duplication • Development of expert panel for the sharing of skills • Development of curricula for the training of current and future health care practitioners

Appendix Z: Clinical Advisory Group Comments

The Clinical Advisory Group (CAG) of the Telemedicine Task Force (Task Force) identified use cases to accelerate telehealth adoption. These use cases are intended to: have an impact on vulnerable populations; be consistent with the goals of health care reform; and be implementable, testable, and cost effective.[234] The use case categories were voted on by the CAG, and subsequently sent to all three advisory groups (CAG, Finance and Business Model, and Technology Solutions and Standards) of the Task Force to review. The following comments were received to the preliminary use cases developed by the CAG.

Preliminary use case list for comment:

1. Improve transitions of care between acute and post acute settings through telehealth:
    i) Movement either direction between long-term care and acute care settings[235]
    ii) Provide psychiatric services to long-term care patients
    iii) Develop long-term care shared savings programs with hospitals
2. The use of telehealth to manage hospital Prevention Quality Indicators such as:
    i) Diabetes management and screening potential such as retinopathy, podiatry, etc.
    ii) Hypertension
    iii) Congestive heart failure
    iv) Chronic obstructive pulmonary disease and asthma
    v) Obesity
3. Incorporate telehealth in hospital innovative payment and service delivery models through ambulatory practice shared savings programs:
    i) Primary Care Nucleus (defined to include all or most of the skill sets listed below)
        a. Family medicine
        b. Internal medicine
        c. Geriatric medicine
        d. Pediatrics
        e. Obstetrics
        f. General surgeon
    ii) Specialists
        a. Behavioral health
        b. Dermatology
        c. Radiology
        d. Pathology

[234] The use cases are not intended to be an exhaustive list or indicate which health care services should be reimbursed by payors.
[235] For purposes of discussion, long-term care includes skilled nursing facilities, assisted living, and independent living.

e. Critical care (tele-ICU)
f. Oncology
g. Rehabilitative and habilitative services
h. Dentistry

iii) Hospital Emergency Departments
a. Cardiac emergencies
b. Pediatric emergencies
c. Stroke
d. Trauma
e. Dentistry

4. Require payor-based medical home programs to factor in reimbursement for telehealth by primary care providers and specialists

Original use case table for comment:

Telehealth Use Case for Future Development	Clinical Applications	Implementation Considerations
1. Emergent telemedicine applications in hospital emergency departments and during transport of critically ill patients 2. Public health screening, monitoring and documentation with data exchange 3. Telehealth in schools for asthma management, diabetes, childhood obesity, behavioral health, and smoking cessation 4. Telehealth for routine and high-risk pregnancies 5. Widespread community site deployment of telehealth services connected to health care professionals and/or the statewide health information exchange 6. Remote mentoring, monitoring and proctoring for the expansion, dispersion and maintenance of skills, supervision, and education	• Assessment of disposition of patient on site *(use cases 1 3,4, and 5)* • Scheduling a health care provider to be available for consultations *(use cases 1, 3 4, and 5)* • Ensure patients are using the appropriate remote- and self-monitoring technology *(use cases 2, 3, 4, and 5)* • Disease surveillance and program quality monitoring *(use cases 2 and 5)* • Preventative care and early screenings (i.e. oral health, vision, allergies, etc.) *(use cases 2, 3, 4, and 5)* • Expert support or supervision by clinicians for the management of complex cases or development of new skill sets *(use cases 1, 3, 4, and 6)*	• Identify appropriate clinical applications for technology devices *(use cases 1 through 6)* • Care provider networks for real-time availability, such as stroke, pediatric and obstetrical emergencies *(use cases 1,3 and 4)* • Inconsistencies of wired and wireless connectivity, including latency, dropouts, or complete loss of connectivity in certain geographic regions of Maryland *(use cases 1through 6)* • Access to images and other relevant clinical information *(use cases 1, 2,3, and 4)* • Ensuring telehealth services are reimbursable and investment in infrastructure compensated *(use cases 1 through 6)* • Coordinate and collaborate with existing programs while avoiding unnecessary duplication *(use case 1,2,3, 4, and 5)* • Development of expert panel for the sharing of skills

Telehealth Use Case for Future Development	Clinical Applications	Implementation Considerations
		(use case 6) • Development of curricula for the training of current and future health care providers *(use case 6)*

Comments Received

The following list depicts the comments received and changes made to the use case categories.

1) Jillian Aldebron

    a. Editorial changes to narrative[236]

    MHCC Response: Accepted

    b. Key comments: include *behavioral health* under 3. iii; include patient engagement; acknowledge that telehealth is already being used to some extent in these and other applications, and that the identification of future use cases is not meant to imply that progress in these areas should not continue but rather to establish priorities for intervention at the statutory and financial levels that would encourage telehealth expansion for the uses identified

    MHCC Response: Key points from comments were incorporated in the report as appropriate: patient engagement; acknowledge that telehealth is being used to some extent in these and other applications, and identification of future use cases is meant to establish priorities for intervention; identification of use cases is not intended to indicate reimbursement for only these use cases; include behavioral health under hospital emergency departments

2) Theodore Brown

    a. Include a more explicit reference for the inclusion of the patient/client home as a critical remote site for use case options. The efficient use of medical expertise and resources requires the use of technology to help empower greater patient participation and responsibility for their health care and well being. The option to receive and access health care from the home will play a major role as the first level of intervention. The patient's home is fundamental to appreciating the true benefits and application of Telemedicine/Health Technology. Diagnostic, preventative, primary care, and post discharge convalescent care services can, should and will be transferred to the patient's home. The appropriate platforms and applications exist to proceed with implementing models of use. Excluding the Home as a fundamental

[236] The individual that commented made editorial changes that while not listed, MHCC determined were helpful and accepted.

part of the use case menu greatly undermines the significance, benefits and applications of telemedicine technology.

MHCC Response: Use of telehealth by patients in their home is included under several of the use cases, including use of telehealth to manage hospital prevention quality indicators, incorporate telehealth in hospital innovative payment and service delivery models through ambulatory practice shared savings programs, and require payor-based medical home programs to factor in reimbursement for telehealth by primary care providers and specialists. Implementation options of the use cases for consideration were not included in the report, as the use cases provide overall categories and are not intended to be granular or exhaustive.

b. Would a qualified licensed health provider in Maryland (i.e. Psychiatrist, Clinical Psychologist, Nurse Practitioner, etc.) be able to offer and provide mental health and substance abuse prevention services from their office vs. hospital to their patients in the patient's home via telemedicine/technology as an option? Based upon your response it seems that it would be reimbursed under payor-based home programs? I persist on clarification because this service has been presented as a point of interest and is being considered for implementation hopefully in the fall.

MHCC Response: The use cases for consideration are not intended to be an exhaustive list of all possible telehealth use cases. Additionally, the use cases for consideration are intended to be a list of situations where telehealth could have an impact on risk populations, be consistent with health care reform efforts, and be implementable, testable, and cost effective. The use cases for consideration are not intended to imply which health care services should or should not be reimbursed by carriers. We encourage those considering the implementation of a telehealth pilot to contact the carrier to determine carrier policies regarding telehealth.

3) Howard Haft: The sole comment that I have is that the recommendations still seem to miss the direct to consumer non hospital telemedicine applications such as teledermatology, etc.

MHCC Response: The commentary provided is one of the things in concept that we are aiming to achieve. We identified more clearly the direct to consumer non-hospital telemedicine applications in the document and/or legislative report.

4) Anne Lara: This looks good

MHCC Response: None required

5) Laura Pimentel

a. Under *Emergency Department uses*: add *consultation for psychiatric emergencies*.

MHCC Response: Added

b. Add *Correctional Facilities Infirmaries*. Telehealth communication with emergency departments and specialists can preclude expensive and unnecessary transfers to the hospital.

MHCC Response: The use case considerations are not intended to be an exhaustive list of all possible telehealth use cases; the list of use cases represents the priority views of the CAG.

6) H. Neal Reynolds

   a. Key comments: add to 2.i., *vasculopathy, nephropathy,* and *neuropathy*; and under 3.i., remove *Geriatric Medicine* and add *Internal Medicine*

      MHCC Response: Incorporated

   b. Add Future Use Case Number 7: *Development of curricula for the training of current and future health care providers in the science of telehealth*.

      Add Clinical Applications: *Drive the growth and expansion of telehealth, telemonitoring and telemedicine technologies through education*.
      Implementation Considerations: *Competition for time within already crowded curriculum schedules*.

      MHCC Response: Added, and added new implementation consideration: *Development of curricula for the training of health care providers in telehealth.*

7) Tricia Roddy: Description of the use cases is vague, making it difficult to discern how they will be able to be implementable, testable, and cost-effective. It is unclear which services would be reimbursed and whether services offered would be distinguishable from those already covered.

   MHCC Response: The use cases are not intended to be telehealth application specific, rather to provide a broad framework or construct of use case concepts, allowing for development of more granular use cases to emerge; use case concepts are not payor-specific and may not fit into existing government or private payor programs, programs may need to be re-tooled; use case concepts are intended to create opportunity for more telehealth in the health care sector.

8) Barney Stern

   a. Editorial changes to narrative[237]

      MHCC Response: Accepted.

   b. Not sure what is meant by habilitative services

      MHCC Response: Habilitative services are defined by the National Association of Insurance Commissioners as *health care services that help a person keep, learn or improve skills and functioning for daily living.*

   c. What is meant by public health screening, monitoring, and documentation with data exchange? Does this refer to CRISP? Data exchange with who/what? Otherwise, looks good.

[237] The individual that commented made editorial changes that while not listed, MHCC determined were helpful and accepted.

MHCC Response: CRISP could be the data exchange entity; however, we did not want to limit data exchange to CRISP only, since organizations are now beginning to set up point-to-point connections, and also EHR vendors are implementing HIE features.

For public health screening and monitoring via telehealth to be most effective, data would have to be exchanged, both past histories as well as data collected through the telehealth encounter.

d. Add to future innovative telehealth use cases resident supervision in teaching hospitals.

MHCC Response: The future use case number ten could in application, include resident supervision in teaching hospitals.

9) Debra Wolf: Looks pretty comprehensive, under specialties you could suggest neurodevelopment pediatrics – not sure if this is encompassed in pediatrics, and movement disorder clinics.

MHCC Response: Specific examples of applications of the use cases for consideration are not included in the report, as the use cases provide overall categories and are not intended to be granular or exhaustive.

Appendix AA: Additional Telehealth Use Case Applications

The Clinical Advisory Group (CAG) of the Telemedicine Task Force recommended telehealth use cases, which they viewed as broad enough to enable various telehealth applications by State-regulated payors and practitioners. Applications to illustrate the use cases were provided in the report. The following represents additional applications for select use cases, as proposed by H. Neal Reynolds, M.D., Chair of the CAG:

1. The use of telehealth to improve care coordination and transitions between long term and acute care settings improves care coordination.[238,239] Comprehensive care facilities (CCF)[240] often do not have access to primary care, psychiatric, and other health care services when needed. Telehealth will enable better coordinated care by virtually connecting a CCF with a physician and other support services.[241]

   Application Example: A remote physician makes routine evening rounds at the CCF, meeting with nursing to make timely pre-emptive medical interventions before the development of symptomotology, and initiate therapy thereby avoiding a transfer to an acute care facility

2. Widespread community site deployment of telehealth services connected to health care practitioners and/or the statewide HIE to increase access to health care services and transmission of health-related information, especially in underserved areas.[242] Remote monitoring and medical kiosks with telehealth services provide early intervention and prevent more acute health conditions.[243]

   Application Example: A patient in a remote county of Maryland, without access to transportation to his primary care provider 30 miles to the north, goes to a Medical Kiosk for routine blood pressure monitoring. The reading is then forwarded to his/her primary care provider or to the State-Designated health information exchange.

3. Remote mentoring, monitoring, and proctoring for the expansion, dispersion, and maintenance of skills, supervision, and education. Many studies show that telehealth helps physicians learn critical skills in a variety of specialties.[244] Curricula for the training of current and future health care providers on the use of telehealth will need to be developed.

   Application Example: A bariatric surgeon at a major medical center performs a new technique of minimally invasive surgery to plicate the stomach. Clinicians from around the state are invited to witness the procedure remotely, hear instructive dialogue as the case

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[238] Care coordination refers to managing a patient's care by collaborating with other health care providers as needed, including nurses, physician assistants, pharmacists, nutritionists, social workers, and educators, specialists, hospitals, and community services.
[239] Long-term care refers to skilled nursing facilities, assisted living, and independent living.
[240] The term in Maryland law for a nursing home, sometimes also known as a Medicare skilled nursing facility (SNF).
[241] Health Affairs, *Use of Telemedicine Can Reduce Hospitalizations of Nursing Home Residents and Generate Savings for Medicare,* February 2014.
[242] Medical kiosks can be installed in accessible locations, such as drug stores or community centers, to enable patients to interact with providers through audio video conferencing; remote monitoring devices can also be installed to stream biomedical information in real time to the virtual provider.
[243] Journal of Telemedicine and e-Health*, Community-Based Telemonitoring for Hypertension Management: Practical Challenges and Potential Solutions*, October 2011.
[244] Journal of Telemedicine and e-Health*, Medical Connectivity,* April 2011.

proceeds and ask questions of technique in real time. New knowledge is dispersed widely and efficiently directly for the experts without major expense of travel.

4. Remote mentoring, monitoring, and proctoring for the expansion, dispersion, and maintenance of skills, supervision, and education. Many studies show that telehealth helps practitioners learn critical skills in a variety of specialties.[245] Curricula for the training of current and future health care providers on the use of telehealth will need to be developed.

   Application Example: A trauma surgeon uses audio video conferencing to remotely guide a general surgeon in the treatment of a car accident, multi-trauma patient. The trauma surgeon provides expertise to the general surgeon, who is able to stabilize the patient. In this application, telehealth enables timely stabilization of the patient. Ultimately, the patient is able to stay at the community facility without incurring the expense of ground or air transport to the more expensive State trauma center and can remain in proximity of family.

The CAG indicated that clinical guidelines will need to be developed by organizations using telehealth to identify the appropriateness of a telehealth intervention based on the patient's condition. The following represents an example of clinical guidelines for the use of telehealth, as proposed by H. Neal Reynolds, M.D., Chair of the CAG:

Disease State	Criteria for Enhanced Monitoring	Monitoring
Congestive Heart Failure	1. Ejection fraction < 45% 2. More than 1 Hospitalization for CHF per year 3. Weight gain more than 10 lbs in 60 days	1. Daily weights with reporting daily to network
Diabetes Mellitus	1. HgbA1C > 9% 2. ≥ 40 units total insulin 3. DKA more than once per year 4. ≥ 3 oral medications required for control	1. Home glucose monitoring with daily reporting to Network till advised otherwise
Hypertension	1. SBP > 180 2. DBP > 115 3. Admission ever for malignant hypertension or hypertensive emergency 4. Cerebro-vascular event related to uncontrolled hypertension 5. > 3 oral medications required	1. Daily home blood pressure monitoring and daily reporting to network till advised otherwise
Chronic Obstructive Pulmonary disease	1. Uses home oxygen 2. Pulmonary function tests demonstrating Forced Expiratory Volume in 1	1. Home pulse oximetry (SpO2) and report to network for set individualized criteria 2. Peak Expiratory Flow (PEFR)

[245] Journal of Telemedicine and e-Health, *Medical Connectivity,* April 2011.

	second (FEV1) < 1 liter 3. Admission to hospital requiring artificial life support ever 4. Sleeps in a chair 5. Cannot perform activities of daily living independently	and report for individualized set criteria

Appendix BB: ATA Telehealth Standards and Guidelines

The American Telemedicine Association (ATA) provides standards and guidelines intended to set a baseline for high-quality care delivered via telehealth. Current standards and guidelines are included below. Additional information is available at: www.americantelemed.org.

Begin quoted text

Clinical Guidelines for Telepathology, Published August 2014
This document is an update to the original ATA telepathology guideline and provides new and updated guidance on specific applications, practice, benefits, limitations, and regulatory issues that may arise in the practice of telepathology. This guideline covers clinical applications of telepathology to include primary diagnosis, intraoperative consultations, secondary consultations, and quality assurance that may result in amended cases.

Guidelines for TeleICU Operations, Published May 2014
The TeleICU Guidelines were developed to assist practitioners in providing assessment, medical intervention, continuous monitoring and/or consultation to the critical care population using telecommunication technologies.

Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interactions, Published May 2014
These guidelines provide an update to the previously published Core Standards for Telemedicine Operations (Nov. 2007) and cover fundamental requirements to be followed when providing healthcare services using telecommunications technologies, and other electronic communications between patients, practitioners and other healthcare providers.

A Lexicon of Assessment and Outcome Measures for Telemental Health, Published November 2013
This lexicon is a research tool developed to aid telemental health professionals in the selection of assessment and outcome measures. This resource will help grow understanding in the field, allow for broader comparisons, and support better generalization of findings.

Practice Guidelines for Video-Based Online Mental Health Services, Published May 2013
Covering the provision of mental health services when using real-time videoconferencing services transmitted via the Internet, including a personal computer with a webcam or a mobile communications device (e.g., "smart phone", laptop, or tablet) with two-way camera capability.

Quick Guide to Store-Forward and Live-Interactive Teledermatology for Referring Providers, Published April 2012
A concise overview of work-flows, equipment requirements and best practices for both Live (synchronous) and Store-and-Forward (asynchronous) teledermatology. Funding support for this initiative was provided by United Health Foundation.

Expert Consensus Recommendations for Videoconferencing-Based Telepresenting, Published October 2011
Administrative, technical and clinical standards for health professionals using videoconferencing-based telepresenting to connect patients with remote medical providers. Funding support for this initiative was provided by United Health Foundation.

Telehealth Practice Recommendations for Diabetic Retinopathy, Published February 2011
Recommendations for designing, implementing, and sustaining an ocular telehealth care program. It specifically addresses current clinical, technical, and administrative issues that form the basis for evaluating Diabetic Retinopathy with telehealth services and technologies.

A Blueprint for Telerehabilitation Guidelines, Published October 2010
The key administrative, clinical, technical, and ethical principles that should be considered in the course of providing telerehabilitation services. They are based primarily on the American Telemedicine Association's Core Standards for Telemedicine Operations, and describe additional considerations that are present across applications within telerehabilitation and its related fields.

Practice Guidelines for Videoconferencing-Based Telemental Health, Published October 2009
Guidelines to assist in the development and practice of coherent, effective, safe and sustainable telemental health practices. The guidelines focus telemental health serviced delivered through two-way, interactive (synchronous) videoconferencing.

Evidence-Based Practice for Telemental Health, Published July 2009
The document is a companion piece to ATA's Practice Guidelines for Videoconferencing-Based Telemental Health, with reference and support for decision-making in developing and providing telemental health services.

Practice Guidelines for Teledermatology, Published December 2007
These guidelines are designed to aid in the development and practice of coherent, effective, safe and sustainable teledermatology practices. The document is a consensus operational best practice reference, based on clinical empirical experience, as well as an educational tool to aid practitioners in providing appropriate telehealth care for patients.

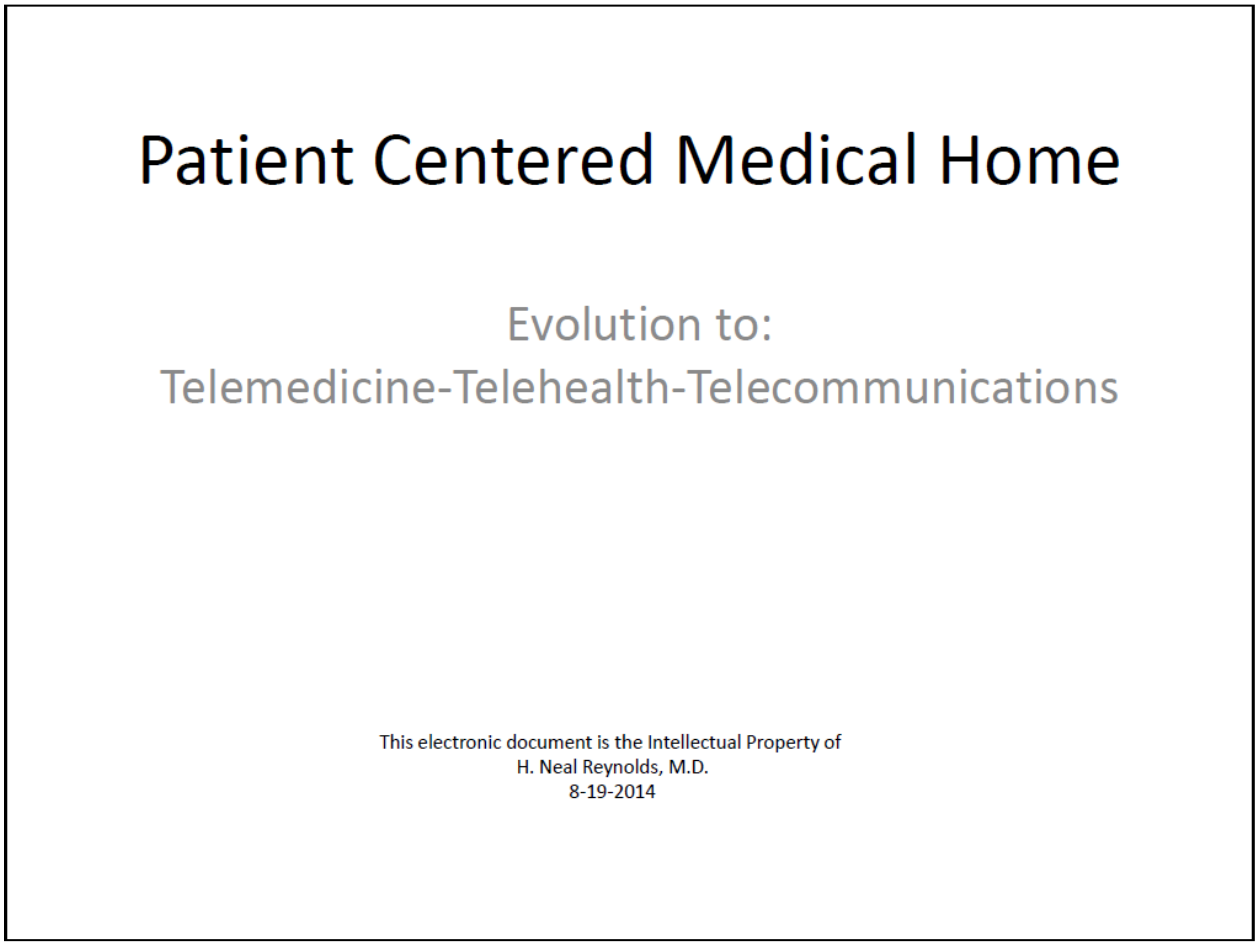
Home Telehealth Clinical Guidelines, Published 2003
These guidelines encompass the diverse applications for home telehealth technology and establish a set of universal principles guiding the development and deployment of home telehealth in the future.

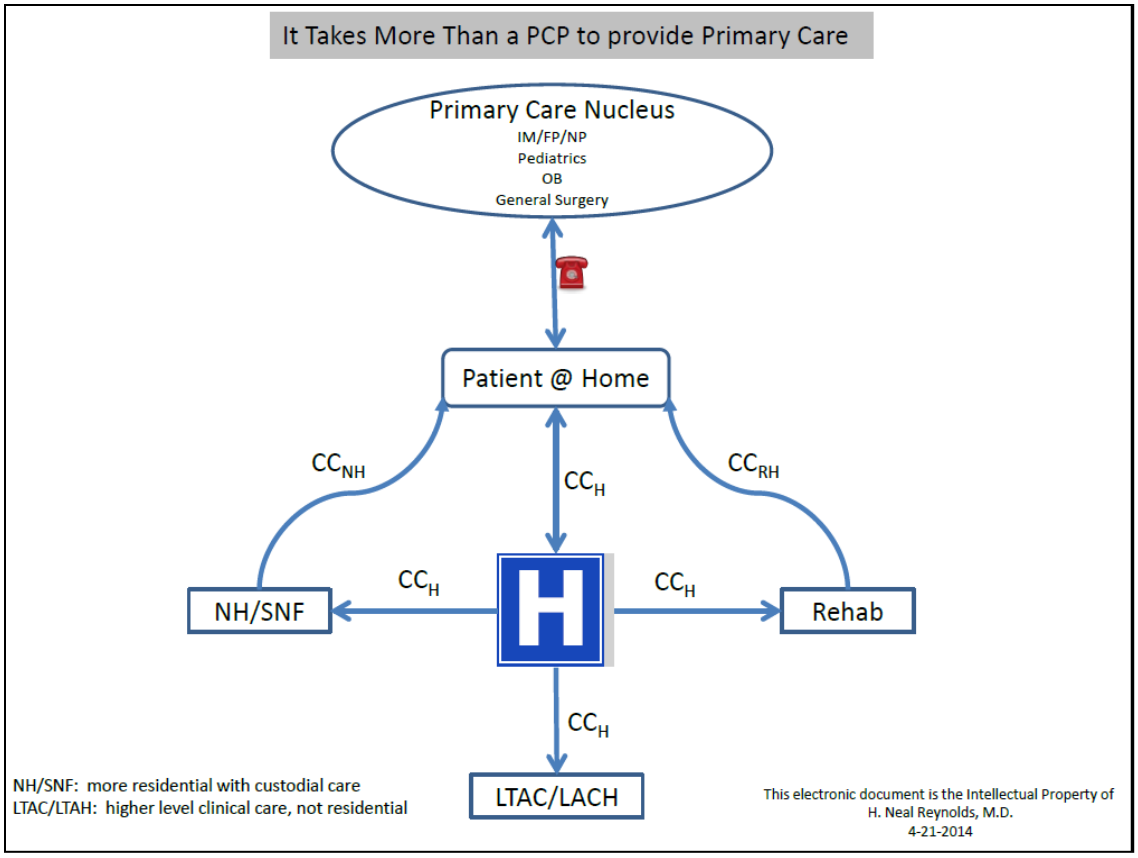
Clinical Guidelines for Telepathology, Published May 1999
Clinical guidelines for telepathology, generally applicable to all three types of telepathology: static (store and forward), dynamic (synchronous), and hybrid (static-dynamic) implementations.

End quoted text

Appendix CC: PCMH and Telehealth Construct

The following illustrations provide a graphic representation of the concept of a Patient Centered Medical Home (PCMH), including patient flow, institutions involved, and necessary personnel to support the PCMH. Current and proposed telehealth systems are also represented, with orange clouds or grey clouds respectively. These illustrations were developed by and are the intellectual property of H. Neal Reynolds, M.D., Chair of the Clinical Advisory Group.




It Takes More Than a PCP to provide Primary Care
Primary Care Nucleus
IM/FP/NP
Pediatrics
OB
General Surgery
Patient @ Home
CC_NH
CC_H
CC_RH
CC_H
CC_H
NH/SNF
Rehab
CC_H
LTAC/LACH
NH/SNF: more residential with custodial care
LTAC/LTAH: higher level clinical care, not residential
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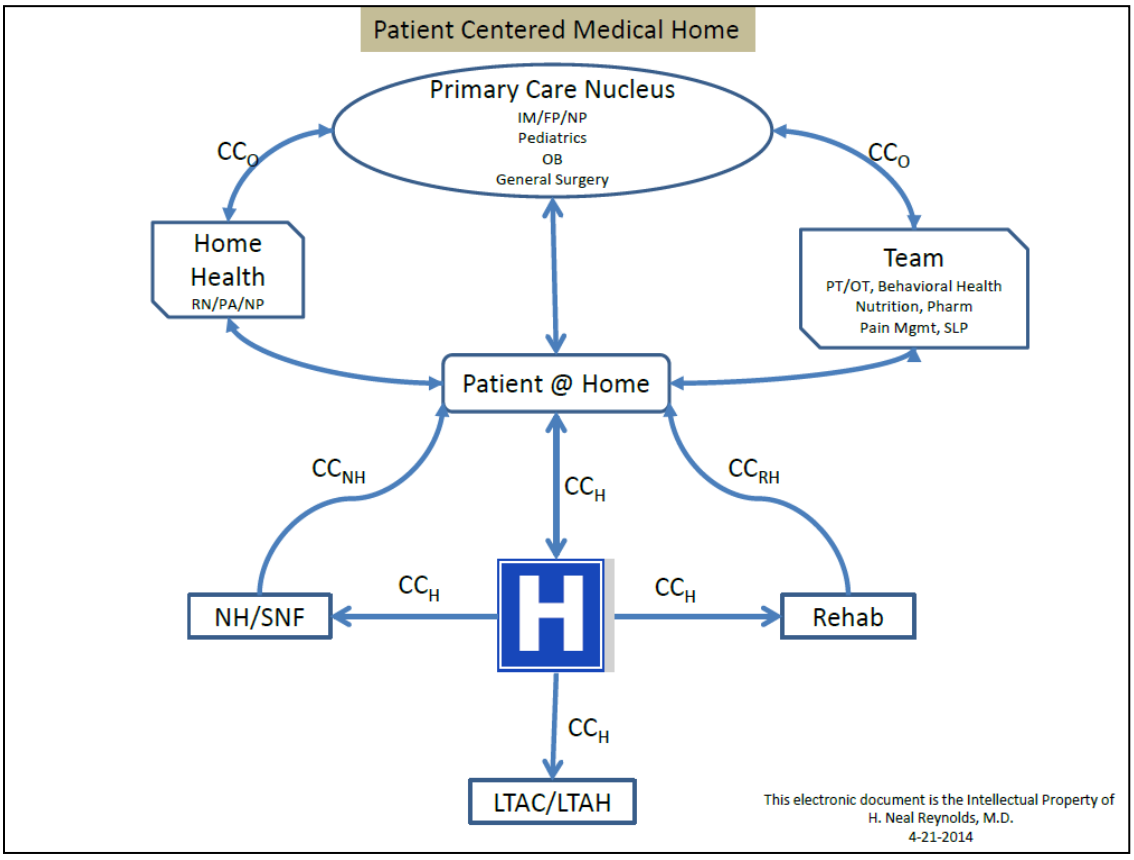
4-21-2014


Patient Centered Medical Home
Primary Care Nucleus
IM/FP/NP
Pediatrics
OB
General Surgery
CC_O
CC_O
Home Health
RN/PA/NP
Team
PT/OT, Behavioral Health
Nutrition, Pharm
Pain Mgmt, SLP
Patient @ Home
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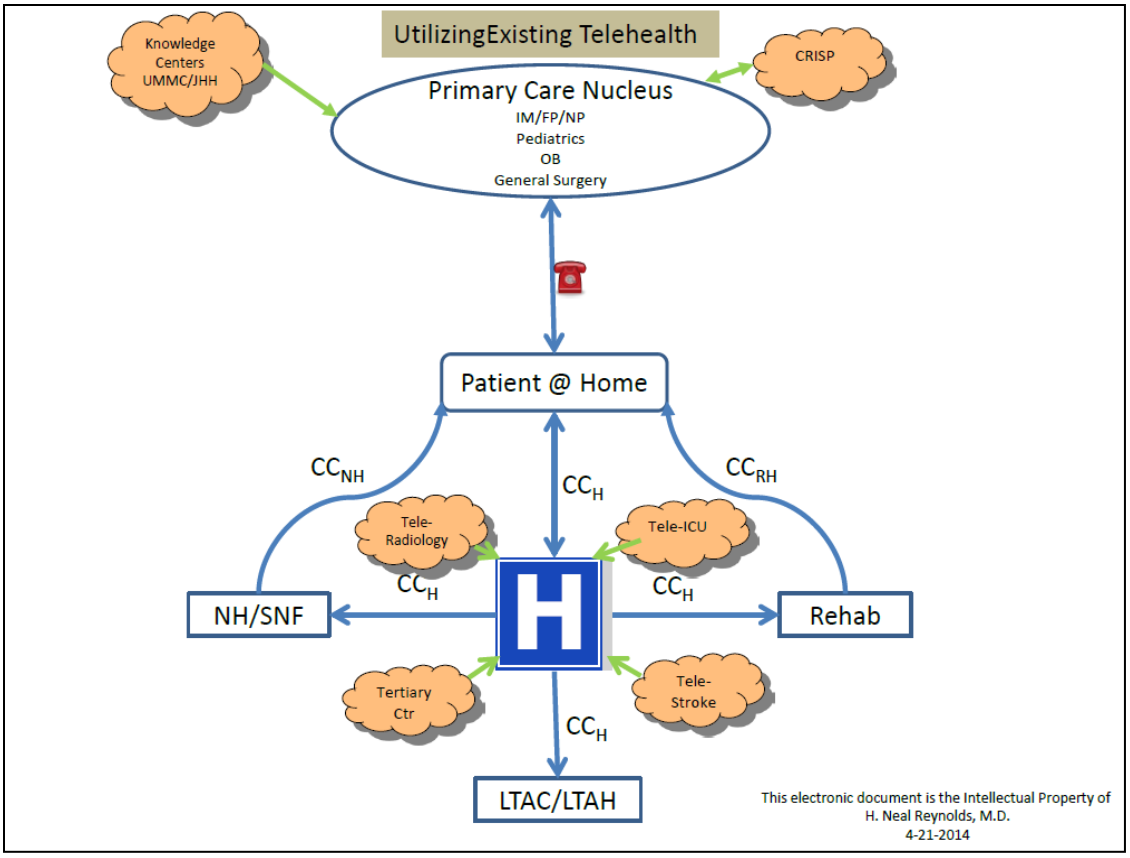
4-21-2014


UtilizingExisting Telehealth
Knowledge Centers UMMC/JHH
CRISP
Primary Care Nucleus
IM/FP/NP
Pediatrics
OB
General Surgery
Patient @ Home
CC_NH
CC_H
CC_RH
Tele-Radiology
Tele-ICU
NH/SNF
Rehab
Tertiary Ctr
Tele-Stroke
LTAC/LTAH
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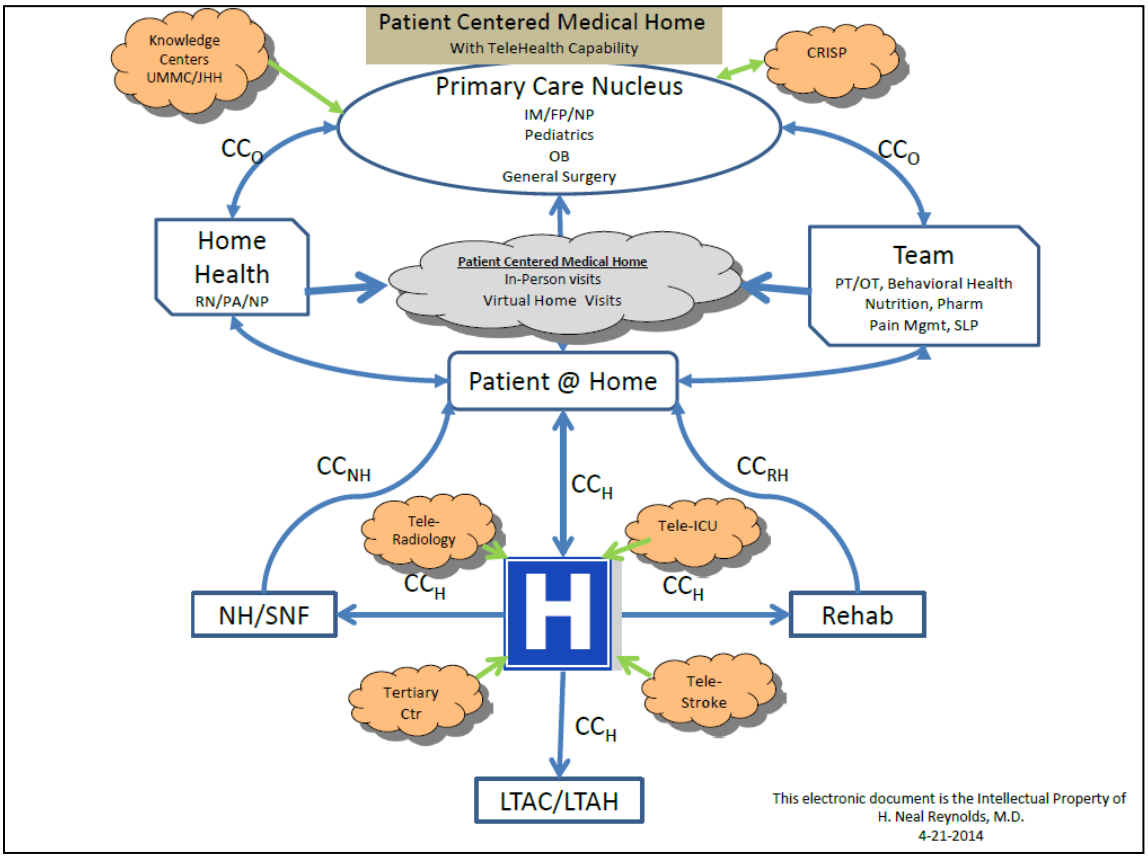
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With TeleHealth Capability
Knowledge Centers UMMC/JHH
CRISP
Primary Care Nucleus
IM/FP/NP
Pediatrics
OB
General Surgery
CC_O
Home Health
RN/PA/NP
Patient Centered Medical Home
In-Person visits
Virtual Home Visits
Team
PT/OT, Behavioral Health
Nutrition, Pharm
Pain Mgmt, SLP
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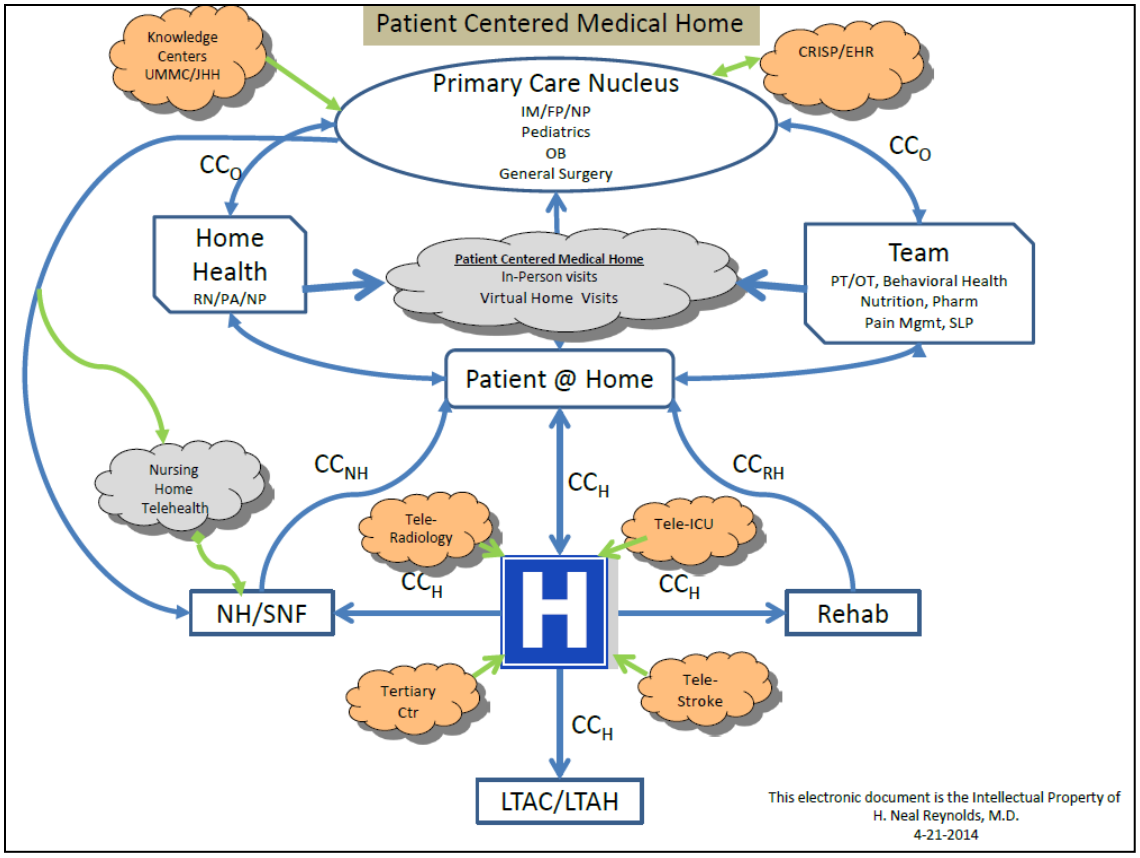
Patient Centered Medical Home
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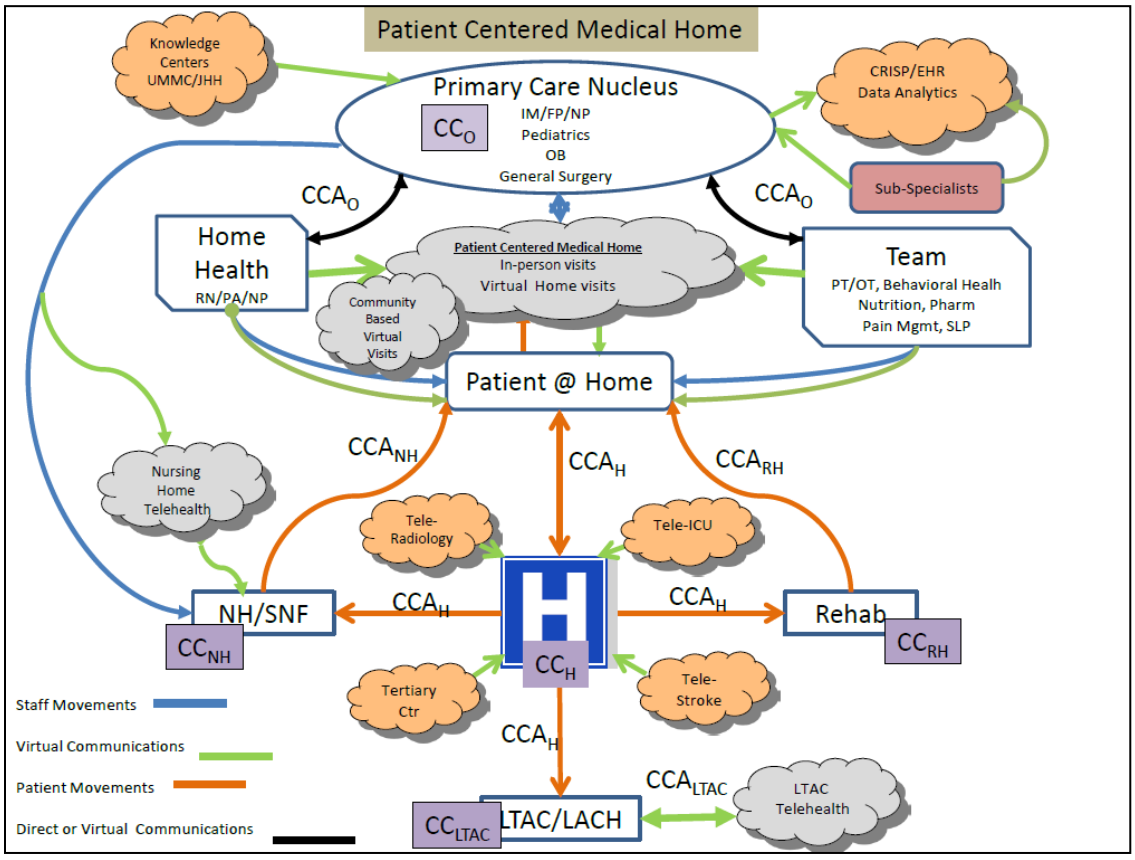
Patient Centered Medical Home
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Pediatrics
OB
General Surgery
CRISP/EHR
Data Analytics
Sub-Specialists
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Community Based Virtual Visits
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CCA_RH
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Tele-ICU
NH/SNF
CCA_H
CCA_H
Rehab
CC_NH
CC_H
CC_RH
Tertiary Ctr
Tele-Stroke
CCA_H
Staff Movements
Virtual Communications
Patient Movements
Direct or Virtual Communications
CCA_LTAC
LTAC Telehealth
CC_LTAC
LTAC/LACH

Appendix DD: Finance and Business Model Considerations for Telehealth Use Cases

The 2014 Telemedicine Task Force Finance and Business Model Advisory Group developed the following table to outline finance and business model challenges for implementing the telehealth use cases.

Finance and Business Model Challenges for Telehealth Use Cases		
Implementation Considerations	**Timeframes to Implement**	**Other Comments**
Finance Model • Payment structure • Resolution of billing process for remote facility and delivery site • Clinician blocks time for remote care delivery and monitoring *Business Model* • Remote care coordination • Telehealth payments linked to outcomes • Strategy for virtual care delivery • Develop a common ROI assessment model that includes financial, social, and quality components • Reengineering workflow process	*Payors* • ~ 18 months required for State-regulated payors to implement • Unique challenges for national payors, it is difficult to implement State-specific requirements • Medicaid funding dependent on budget and fiscal year *Practitioners* • ~ 18 months required for practitioners and health systems to implement *Re-evaluation* • ~ 36 months to evaluate quality improvement and practitioner satisfaction	*General* • Telehealth can offer comparable care, more convenient for both practitioners and patients • Timing the investment as technology continues to evolve • Technology investment and maintenance *Use Case Specific* • Practice transformation and redesign • Risk management and mitigation

Appendix EE: Finance and Business Model Advisory Group Comments

The Finance and Business Model (F&B) Advisory Group of the Telemedicine Task Force (Task Force) identified the finance and business model challenges of implementing the use cases to accelerate telehealth adoption. These use cases are intended to: have an impact on vulnerable populations; be consistent with the goals of health care reform; and be implementable, testable, and cost effective.[246] The use case categories were voted on by the CAG, and subsequently sent to all three advisory groups (Clinical Advisory Group, F&B Advisory Group, and Technology Solutions and Standards Advisory Group) of the Task Force to review. The following table depicts the preliminary comments received and changes made to the finance and business model challenges of implementing the use cases.

Preliminary table for comment:

Innovative Telehealth Use Case Categories Implementation Considerations	Timeframes to Implement	Other Comments
Finance Model • Payment structure • Resolution of billing process for remote facility and delivery site • Clinician blocks time for remote care delivery and monitoring *Business Model* • Remote care coordination • Telehealth payments linked to outcomes • Strategy for virtual care delivery • Develop a common ROI assessment model that includes financial, social, and quality components • Reengineering workflow process	*Payors* • ~ 18 months required for State-regulated payors to implement • Unique challenges for national payors, it is difficult to implement State-specific requirements • Medicaid funding dependent on budget and fiscal year *Providers* • ~ 18 months required for providers and health systems to implement *Re-evaluation* • ~36 months to evaluate quality improvement and provider satisfaction	*General* • Telehealth can offer comparable care, more convenient for both providers and patients • Timing the investment as technology continues to evolve • Technology investment and maintenance *Use Case Specific* • Practice transformation and redesign *(use case 3 and 4)* • Risk management and mitigation *(use cases 1 and 2)*

[246] The use cases are not intended to be an exhaustive list or indicate which health care services should be reimbursed by payors.

Comments Received

1) Howard Haft
    a. Even as a person who has been involved in the telemedicine field I find the table a bit confusing. The content in the columns does not seem to link horizontally with the Use Case Categories it may be that there is no intention to do so but most readers will be searching for those horizontal associations in a table.

       MHCC Response: The table is not intended to identify associations horizontally across the table. The MHCC used the table format for discussion only; the table is not in the body of the report.

    b. The use case Categories should have at least one clear example of each for example in Category 3- *direct to consumer telemedicine healthcare consultation from primary care providers* - the description is-*Incorporate telehealth in hospital innovative payment and service delivery models through ambulatory practice shared savings programs* In order to separate the description from the business and financial model it could be modified to *Incorporate telehealth in hospital and ambulatory service delivery models.*

       MHCC Response: Incorporated, and use case applications as examples are identified in the report.

2) Michelle Clark
    a. Stress the need to integrate any telemedicine happening into the workforce pipeline. At every level from the Certified Nursing Assistant to Med School/Residency Programs here in Maryland. We won't encourage the future use if we aren't training the workforce in how to deliver care via telemedicine but I see that it is in the implementation considerations which is great (and maybe it was there before) but great to see and reiterating the need for stressing this somewhere in final recommendations.

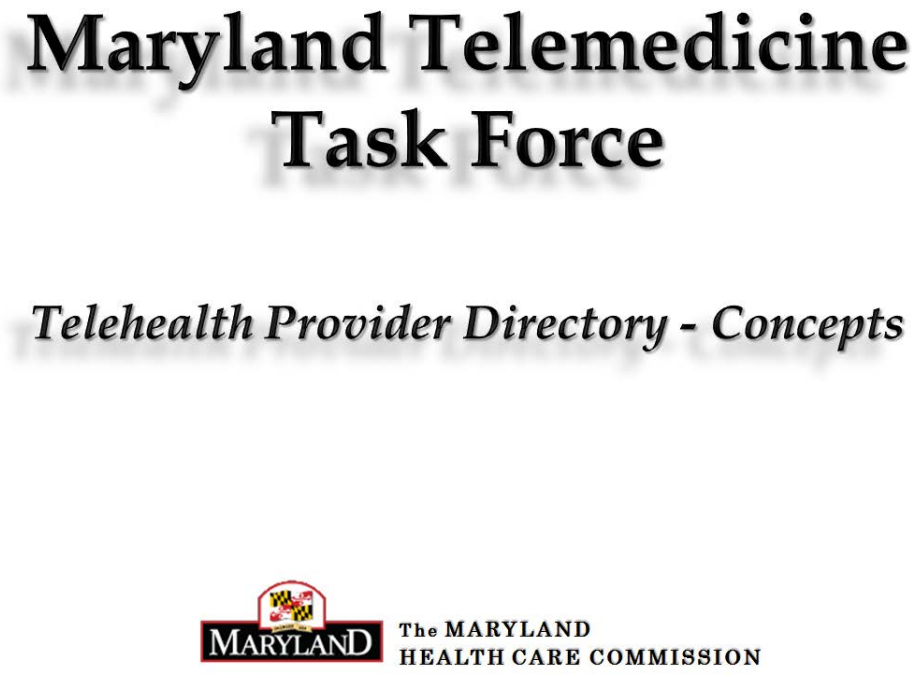
       MHCC Response: The telehealth use case *remote mentoring, monitoring and proctoring for the expansion, dispersion and maintenance of skills, supervision, and education* is intended to train the workforce how to incorporate telehealth into their care delivery.

3) Anne Lara: The content of the document is very comprehensive. Thank you for sharing.

   MHCC Response: None required

Appendix FF: Wireframe Concepts for Telehealth Provider Directory

The 2014 Telemedicine Task Force Technology Solutions and Standards Advisory Group developed the following wireframe concepts to illustrate the information that will be included in the telehealth provider directory.



Background

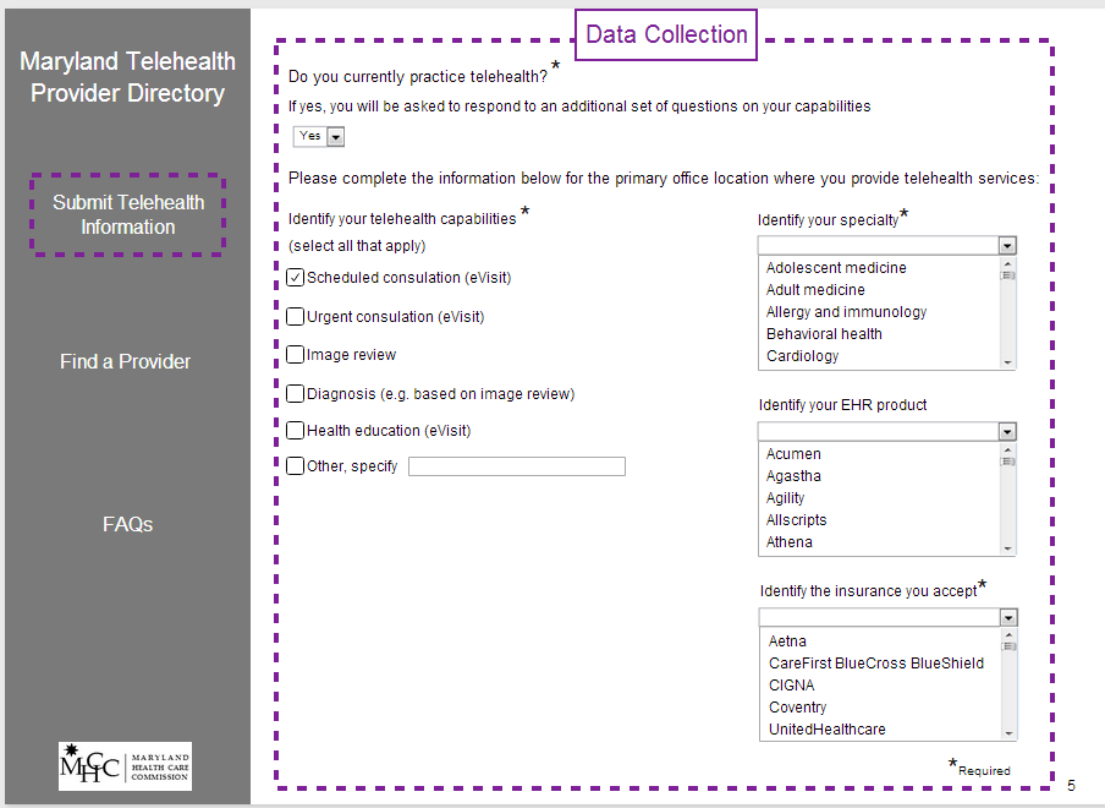
- The Telemedicine Task Force Technology Solutions and Standards Advisory Group identified as a barrier to telehealth diffusion limited availability of information about providers rendering telehealth services
- An online telehealth provider directory would enable providers and consumers to identify providers who are delivering health care services using telehealth
- The telehealth provider directory would be a listing of telehealth providers, including clinical services provided and technology capabilities

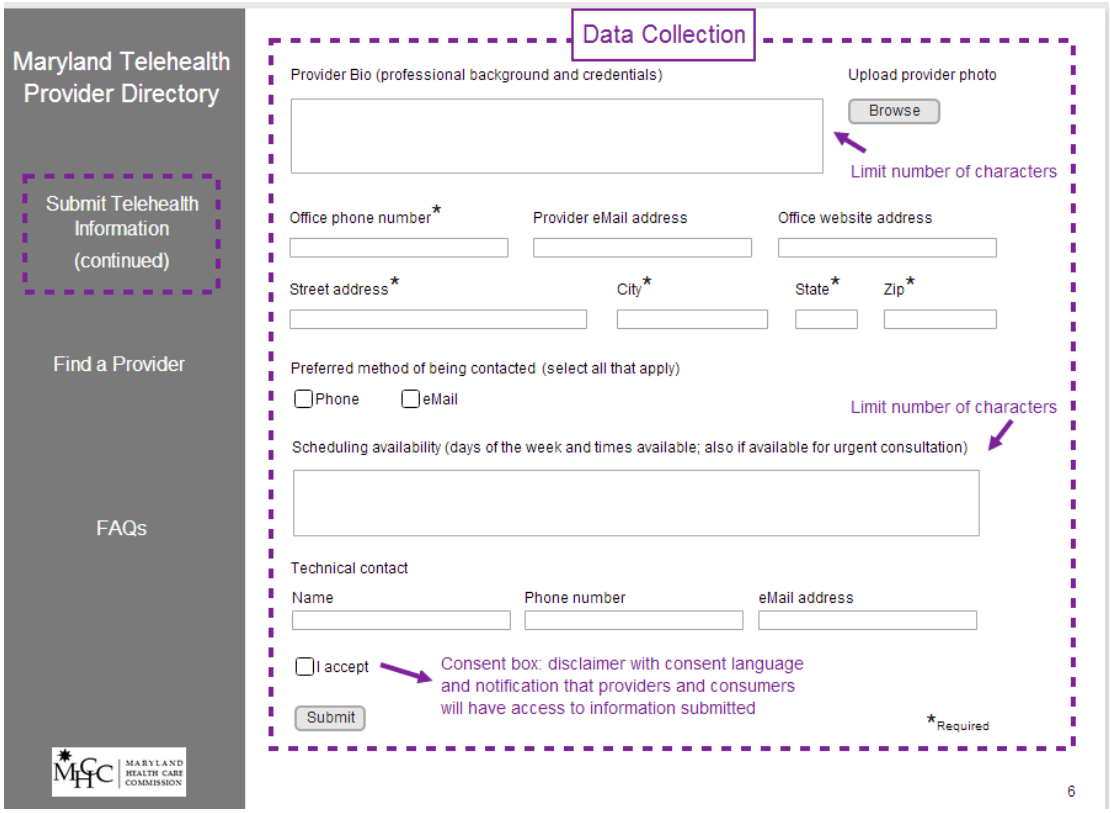
Draft Concepts for Wireframes

Data Collection

The telehealth provider directory would include an online data collection form where providers would be able to submit information about their telehealth capabilities; institutions as well as individual providers would be able to submit information to the directory

4





Find a Provider

The telehealth provider directory would include a search function where providers and consumers would be able to identify providers delivering health care services using telehealth

7

Maryland Telehealth Provider Directory

Submit Telehealth Information

Find a Provider

FAQs

Provider Search

This webpage will contain:

- Purpose of telehealth provider directory (information about telehealth providers in Maryland)

- Search function (to include telehealth capabilities, specialty, insurance information, scheduling availability)

- Disclaimer (function of registry as an information resource, not indicative of reimbursement, not intended for use in emergent situations, information self-reported by providers, links to verify licensure)

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8

Maryland Telehealth Provider Directory

Submit Telehealth Information

Find a Provider (continued)

FAQs

Provider Profile

Contact Information:
- Phone
- eMail
- Address

Insurance information:
- Carriers

Services:
- Telehealth capabilities (scheduled consultation - eVisit)
- Specialty (behavioral health)

Scheduling availability
- Days and times; also if available for urgent consultation

Provider bio
- Professional background
- Credentials

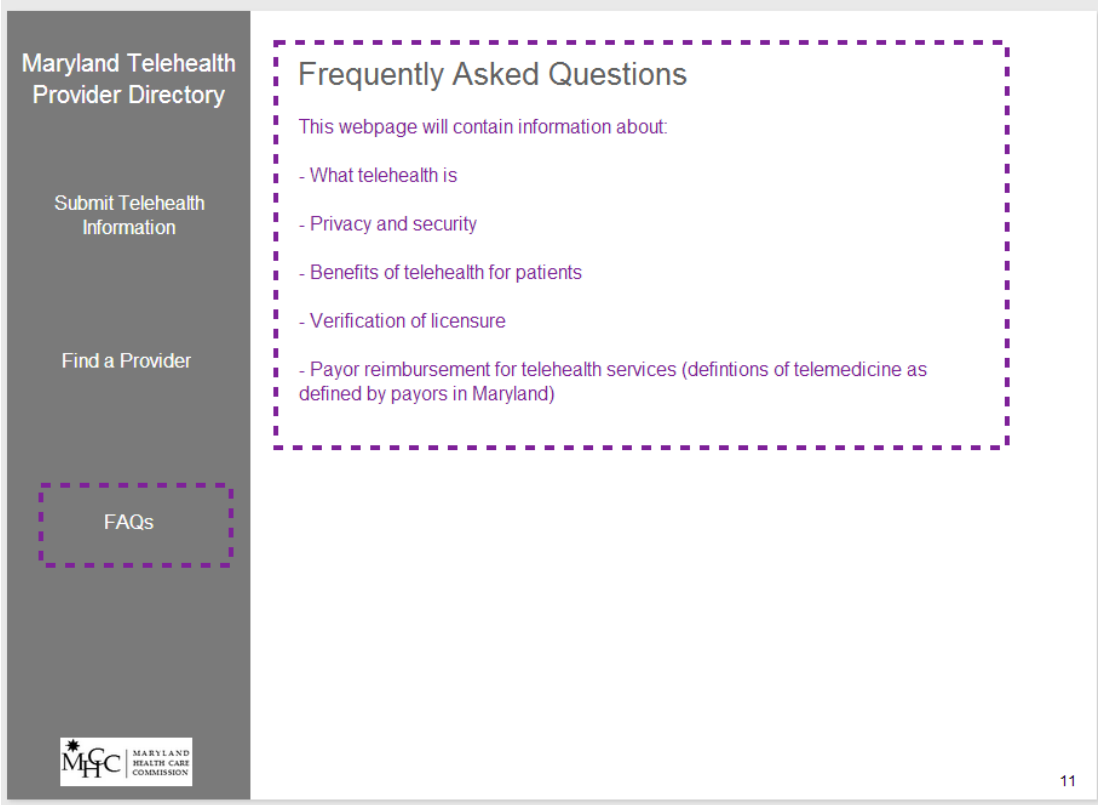
MHCC MARYLAND HEALTH CARE COMMISSION

9

FAQs

The telehealth provider directory would include frequently asked questions (FAQs) where providers and consumers could access additional information about telehealth and the directory

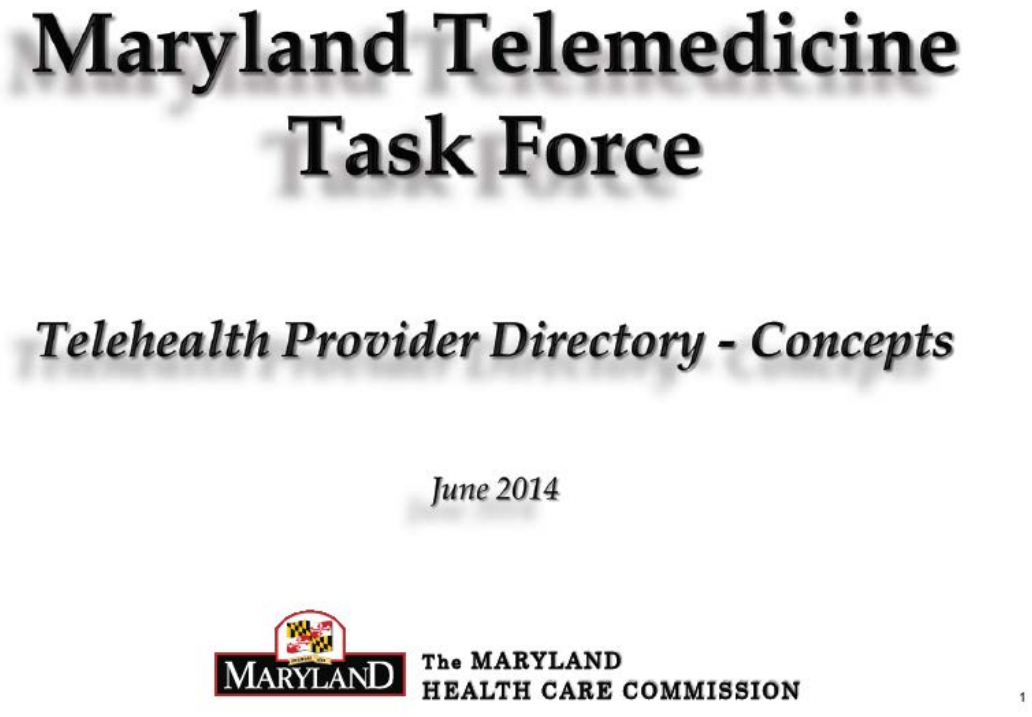
10



Appendix GG: Technology Solutions and Standards Advisory Group Comments

The Technology Solutions and Standards (TSS) Advisory Group of the Telemedicine Task Force (Task Force) developed wireframes for a provider telehealth directory. The wireframes were voted on by the TSS advisory group, and subsequently sent to all three advisory groups (Clinical Advisory Group, Finance &Business Model Advisory Group, and TSS advisory group) of the Task Force to review. The following depicts preliminary comments received and changes made to the wireframes.

Preliminary wireframes for comment:



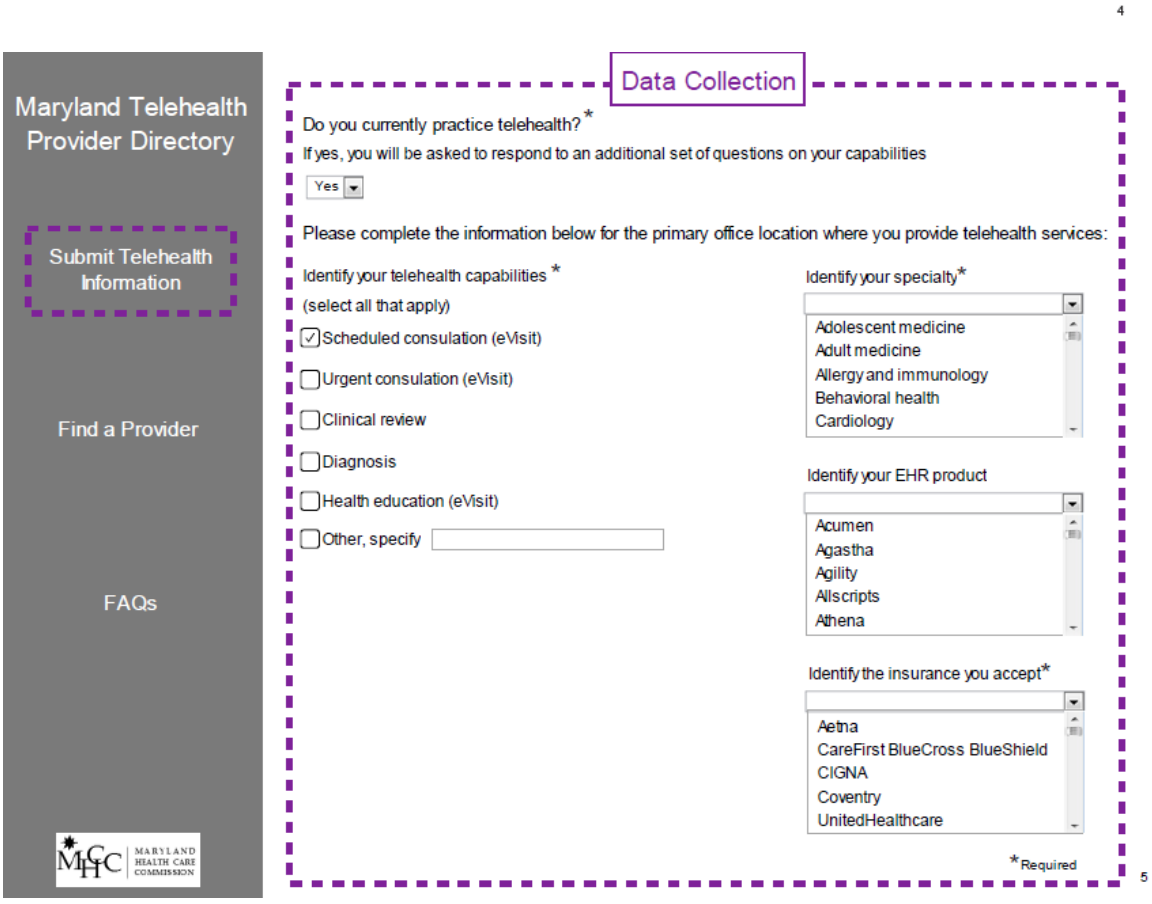
Background

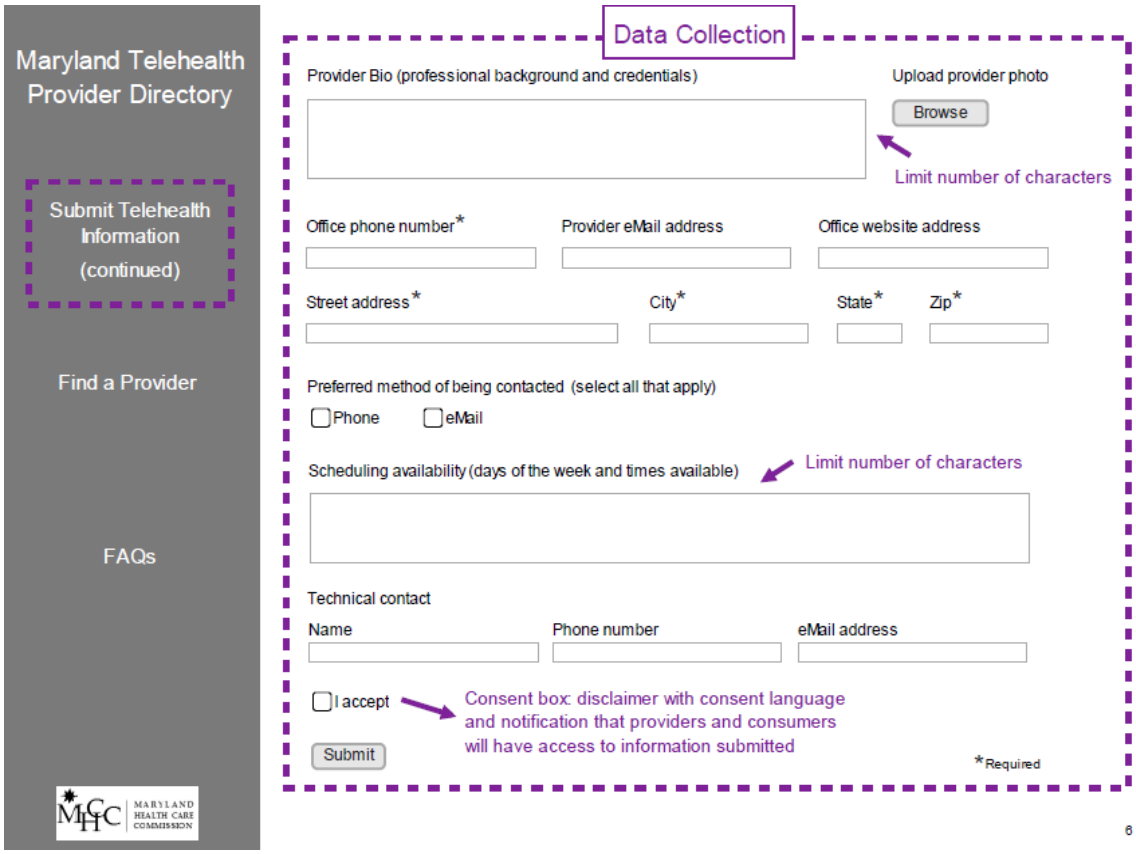
- The Telemedicine Task Force Technology Solutions and Standards Advisory Group identified as a barrier to telehealth diffusion limited availability of information about providers rendering telehealth services
- An online telehealth provider directory would enable providers and consumers to identify providers who are delivering health care services using telehealth
- The telehealth provider directory would be a listing of telehealth providers, including clinical services provided and technology capabilities

Draft Concepts for Wireframes

Data Collection

The telehealth provider directory would include an online data collection form where providers would be able to submit information about their telehealth capabilities; institutions as well as individual providers would be able to submit information to the directory





Find a Provider

The telehealth provider directory would include a search function where providers and consumers would be able to identify providers delivering health care services using telehealth

7

Maryland Telehealth Provider Directory

Submit Telehealth Information

Find a Provider

FAQs

MHCC MARYLAND HEALTH CARE COMMISSION

Provider Search

This webpage will contain:

- Purpose of telehealth provider directory

- Search function (to include telehealth capabilities, specialty, insurance information, scheduling availability)

- Disclaimer (function of registry and emergent situations, information self-reported by providers with link to Maryland Board of Physicians to verify licensure)

8

Maryland Telehealth Provider Directory

Submit Telehealth Information

Find a Provider (continued)

FAQs

MHCC MARYLAND HEALTH CARE COMMISSION

Provider Profile

Contact Information:
- Phone
- eMail
- Address

Insurance information:
- Carriers

Services:
- Telehealth capabilities (scheduled consultation - eVisit)
- Specialty (behavioral health)

Scheduling availability
- Days and times

Provider bio
- Professional background
- Credentials

9

FAQs

The telehealth provider directory would include frequently asked questions (FAQs) where providers and consumers could access additional information about telehealth and the directory

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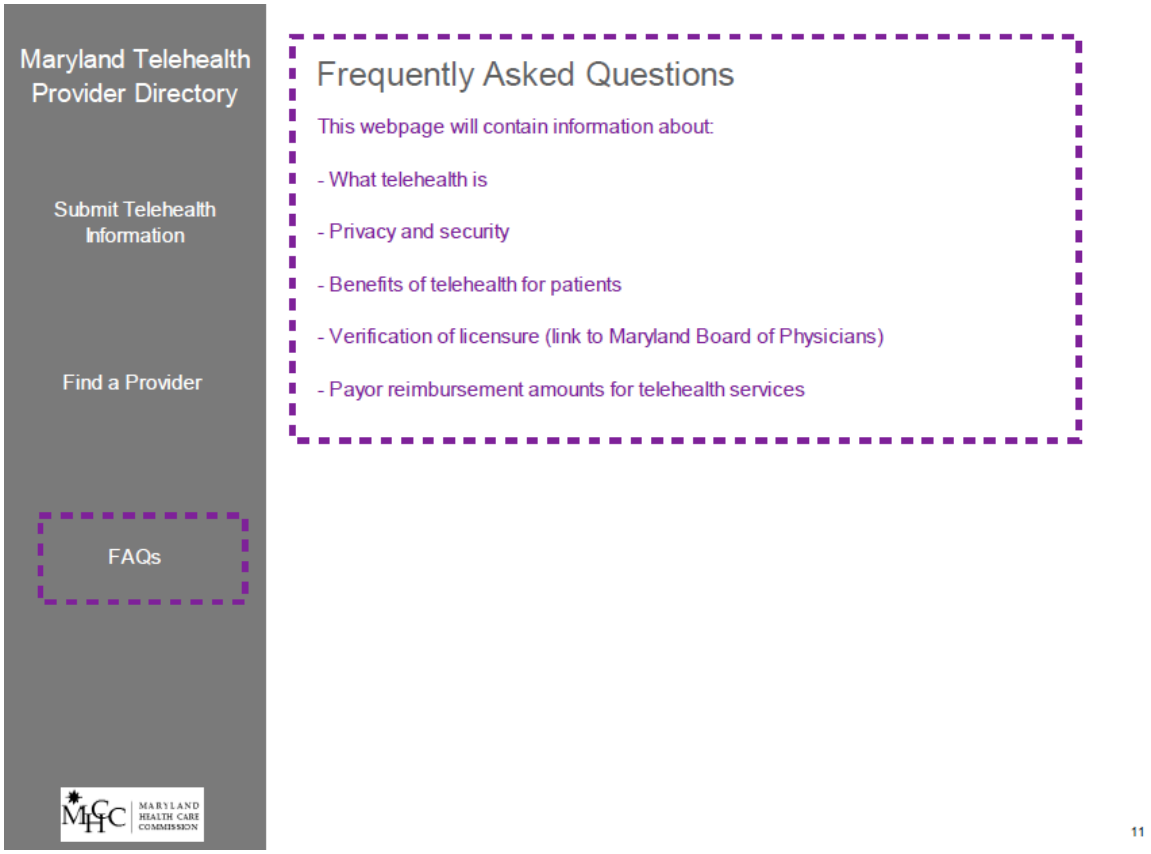

11

Comments Received

1) Jillian Aldebron

   a. Who is responsible for entering information? Deleting information (including, when a provider retires, changes employer, etc.)? Who is responsible for verifying information? General oversight? How often is the directory updated? How are errors corrected - and who is authorized to make the corrections? How are disputes over data validity resolved? Do providers have the ability to enter only certain information - for example, to omit a photo or some other information they may not want to disclose?

      MHCC Response: Implementation of the directory, including these processes, will be finalized if the report recommendations are adopted by the General Assembly. Options for implementation include: collecting the data directly from providers, using the current CRISP provider directory. A disclaimer will be included regarding verification of information.

   b. How are payors involved (they currently control the online provider listings)?

      MHCC Response: Some of the data entry fields, such as photo, would be optional.

   c. Will a carrier be entitled to assume that only those in the directory have telehealth capability and, therefore, deny a claim for telehealth services by a provider who is not listed?

Will a patient be led to assume that because a provider is listed, the service they obtain through telehealth will be reimbursed by their insurance company? Given that insurers (and DHMH) are still able to subject a claim to utilization review (and in some cases may require prior authorization), a patient could potentially be on the hook for the cost. Should there be a disclaimer somewhere?

MHCC Response: If the current CRISP provider directory is used, the information would be submitted by health insurance companies participating with the Maryland Health Connection.

d. I am concerned that the licensure verification links only to the MBOP. What about nursing? Occupational therapy? Dentistry? Psychology? Social work? There are a range of disciplines that need to be included because these providers offer telehealth services now and will increasingly do so in the future.

MHCC Response: The directory is not tied to telehealth reimbursement; carrier medical policies that are in place would dictate reimbursement. Include a disclaimer.

e. How would providers who are not licensed be handled, such as drug counselors?

MHCC Response: Links for the various discipline licensing boards will be included on the resource page.

f. Is this database only for providers physically located in Maryland, or anyone with a current Maryland license (or compact)?

MHCC Response: This would have to be determined during the prototype and technical specification development phase, pending implementation.

g. I don't really understand the purpose of asking at the outset whether the provider offers telehealth services since this database is only for those providers who do.

MHCC Response: Providers located in Maryland. Add information/disclaimer that the directory only includes Maryland providers.

h. Will we have an opportunity to discuss these and other issues as a group?

MHCC Response: These issues have been discussed in the technology group.

i. On the FAQs, payer reimbursement amounts are usually not available.

MHCC Response: Would include definitions of telemedicine as defined by the insurance companies in Maryland.

2) Aviana Cooper: Looks great. Very consumer friendly. However, there is one addition I would like to be placed in the "FAQs" Section. There should be an explanation of how the consumer/patient can utilize the eVist and eScheduling. The question could be stated as: How do I go about utilizing eVisit/eScheduling? What are the requirements needed to use the eVisit/eScheduling? Has this section explained what application they need to download or the type of device that it is compatible with the technology? Presently, that is the only thing that I believe should be added to the draft.

MHCC Response: The website would inform users that they would need to contact a specific provider regarding that provider's scope of telehealth services and operational details (i.e. eScheduling and eVisits), as telehealth capabilities will vary from provider to provider. The wireframes do not include too much detailed information, as they are intended to provide overall concepts for what the directory would look like.

3) Anne Lara: Nicely done

   MHCC Response: None required.

4) Anne Timmons: Looks fine to me

   MHCC Response: None required.

5) Barney Stern

   a. Under "Identify your telehealth capabilities" not sure what "Diagnosis" means. Can delete.

      MHCC Response: Added examples, such as "based on image review"'

   b. Also under "Identify your telehealth capabilities" not sure what is meant by "Clinical review".

      MHCC Response: Changed "Clinical review" to "Image review."

   c. Need to consider how you will define availability for emergency services provided by a team at an institution (e.g. stroke at U Maryland).

      MHCC Response: Changed to "Scheduling availability (days of the week and times available; also if available for urgent consultations)". Include in disclaimer the need to have established connectivity for urgent consultations.

6) Howard Haft

   a. It may be useful to add wireframes or mock ups of the actual website pages leading the consumer and/or the provider to the directory.

      MHCC Response: At this stage, the wireframes are intended to provide overall concepts of what the directory would look like, without being too granular. We would develop mock ups of the actual website pages once the directory is being developed.

7) Cheris Frailey

   a. Looks very nice. SLPs and audiologists may already be included but I wanted to make sure that on page 5 – "Identify your specialty" that speech-language pathologists and audiologists are included in the selection options.

      MHCC Response: If the recommendation to implement a directory is adopted, we would aim to take advantage of existing technology, such as the listing of licensed health care professionals in the Maryland Health Connection. The current provider directory for the Maryland Health Connection is available at:

https://providersearch.crisphealth.org, and includes Audiology and Therapy - Speech as specialties.

b. How are you planning on getting this new directory out to clinicians so that they will put their information into the directory?

MHCC Response: The wireframe concepts for the telehealth provider directory will be proposed to the legislature and if adopted, an outreach strategy would be developed that would include Task Force members.

8) Dan Felton

a. Can you clarify the intent of the phrase "clinical review" on page 5 as one of the selectable options for provider telehealth capabilities? Does that exclusively mean teleICU, or do you mean something more/different than that? If intended just to mean teleICU, could/should that be made explicit?

MHCC Response: At this point, we were not thinking that "clinical review" would be limited to any specific service.

9) Joseph Daniels

a. The Telehealth Provider Directory Concept wireframes is an excellent first step towards providing an easy to use web interface to interconnect patients to medical staff, patients to doctors, medical staff to doctors, and doctors to doctors. The Directory itself should function independently of the underlying telecommunication technology required to support Telehealth services delivery. I believe the importance of it being extremely easy to navigate for patients, medical staff, and doctors has been addressed.

I would be interested to see the output from the Clinical Advisory Group and the Finance and Business Model Advisory Group concepts because of the value of their input. I see a tremendous amount of work to be done by a group(s) focused on telemedicine and its underlying service delivery platform.

MHCC Response: We distributed the output from the Clinical Advisory Group and the Finance and Business Model Advisory Group to all three advisory groups. You may have already seen some of the use case concepts previously distributed. Additional information is forthcoming.

Appendix HH: Telehealth Provider Directory Potential Features

The 2014 Telemedicine Task Force Technology Solutions and Standards (TSS) Advisory Group recommended the development of a telehealth provider directory (telehealth directory). The following table outlines features that were discussed by the advisory group for possible inclusion in the telehealth directory, although it was generally agreed these features would not be appropriate for inclusion. Discussion points regarding the features and rationale for exclusion are listed.

Telehealth Provider Directory	
Potential Feature	**Summary Rationale for Exclusion**
Develop a statewide infrastructure to host real-time telehealth consultations	The function of the telehealth directory is an information resource; the telehealth directory is not a platform for health care service delivery, rather a yellow pages listing of telehealth practitioners. Given the breadth of emerging telehealth technologies and cloud-based platforms that are user-friendly and relatively inexpensive, practitioners and consumers can independently test and initiate an online connection for a telehealth consultation; the telehealth directory would not be the most effective means of hosting such consultations. The telehealth directory will inform users that they would need to contact a specific practitioner regarding that practitioner's scope of telehealth services and operational details. Consumers will also need to ensure services are reimbursable prior to delivery of the service, as the list of practitioners is not intended to denote reimbursement of telehealth services.
Identify the telehealth technology used by the practitioner	The telehealth directory will be a technology-agnostic resource to determine which practitioners are delivering telehealth services. The details about the telehealth technology would need to be discussed independently as practitioners who are completing the data collection form may not know the details of the technology. Updating this information will also be a challenge given the rapidly evolving nature of technology. Thus, information about the telehealth technology will not be necessary to include in the telehealth directory, rather including the contact information for the practitioner's IT specialist, if applicable, would be more efficient.
Show online availability of practitioners who are available immediately for a telehealth consultation	Such a feature may not be reliable if a practitioner is listed as being online while being away from the computer, which means they are not actually available when needed; ensuring that practitioners are available on stand-by may not be feasible for the purposes of the telehealth directory.
Use of telehealth directory for emergency situations	The telehealth directory is not intended to be a resource for emergency situations, which would require 9-1-1 assistance; including information in the telehealth directory about telehealth services for an urgent or immediate consultation would be more appropriate. Remote connections should be tested prior to services being rendered; if telehealth is going to be used for urgent consultations, virtual connectivity would need to have been previously established and tested.

Integrate the telehealth directory with the Mid-Atlantic Telehealth Resource Center (MATRC) Telehealth Provider Database [247]	MATRC has a telehealth directory of practitioners who are located in Pennsylvania; Delaware; Maryland; Washington, DC; Virginia; West Virginia; North Carolina; and Kentucky. TSS advisory group members emphasized the value of exposing the telehealth directory through an existing Maryland resource (CRISP) for streamlined access to local information; currently, MATRC does not have many Maryland practitioners listed. Implementing a Maryland specific telehealth directory would enable Maryland to implement unique features and display unique data.

[247] The MATRC telehealth provider directory is available at: www.matrc.org/where-to-find-telehealth.

Appendix II: Estimated Telehealth Provide Directory Budget

The Chesapeake Regional Information System for our Patients (CRISP) proposed the following budget for integrating telehealth information into the CRISP Provider Search Website. Costs are divided for Phase 1 and Phase 2 as defined in wireframes.

CRISP - Telehealth Provider Directory

Budget Projections - Anticipated Costs

Activity	***Description***	***Year 1 (FY 2016)*** *Implementation ($)*	***Year 2 (FY 2017)*** *Maintenance ($)*	***Year 3 (FY 2018)*** *Maintenance ($)*
	PHASE 1			
Requirements Gathering	CRISP will engage various stakeholders - including MHCC, provider groups, and insurance carriers - to determine appropriate requirements for the Telehealth Provider Directory.	20,000	–	–
Allow Providers to Input Telehealth Capabilities on Provider Search Website	Through the CRISP Provider Search Website, providers - after identity-proofing - can submit their telehealth capabilities. This allows providers to submit their telehealth capabilities without being CRISP users.	20,000	5,000	5,000
Allow Providers to Input Telehealth Capabilities during CRISP Onboarding (Registration) Process	During the *CRISP Onboarding* process, providers can submit their telehealth capabilities. This requires tight integration between Salesforce.com (CRISP's user management vendor) and the CRISP Provider Directory.	75,000	5,000	5,000
Allow Bulk Loading of Telehealth Data	Insurance carriers or provider groups can submit providers' telehealth capabilities in bulk. A standard file format and transport mechanism can be developed to allow for regular submission of telehealth data.	20,000	20,000	20,000
Website: Display Provider Telehealth Preferences	The CRISP Provider Search website will need to be redesigned and tested to accommodate for telehealth data.	25,000	5,000	5,000

CRISP - Telehealth Provider Directory

Budget Projections - Anticipated Costs

Activity	***Description***	***Year 1 (FY 2016)*** *Implementation ($)*	***Year 2 (FY 2017)*** *Maintenance ($)*	***Year 3 (FY 2018)*** *Maintenance ($)*
Support Desk	The CRISP Support Desk will be required to assist providers in submitting telehealth data as well as assisting consumers with questions regarding telehealth data.		15,000	15,000
Phase 1 Total		***$160,000***	***$50,000***	***$50,000***
PHASE 2				
Requirements Gathering	CRISP will engage various stakeholders for communication tools and indicators to include in the Telehealth Provider Directory. Options include an availability indicator, chat window, e-mail, voice call, and Direct Messaging.	30,000	–	–
Communication Tools	CRISP will build the appropriate communication tools and indicators determined during the *Requirements Gathering* process.	80,000	10,000	10,000
Phase 2 Total		***$110,000***	***$10,000***	***$10,000***
CUMULATIVE TOTAL		**$270,000**	**$60,000**	**$60,000**

Appendix JJ: Telemedicine Task Force Comments on Draft Report

The Telemedicine Task Force (Task Force) reviewed a draft *Maryland Telemedicine Task Force Final Report* (report) in September 2014. The following depicts comments received and changes made to the report.

1) Jillian Aldebron

   a. Editorial changes.

      MHCC Response: Accepted.

   b. Overall, I think you did a great job! As Dr. Reynolds acknowledges, however, there is a pervasive tendency to focus on "medicine" and "physicians" (two separate issues). I've made some suggestions that I hope will make for a broader understanding by legislators and the health care community of the potential that exists for telehealth technology to improve the quality and reach of services across the entire spectrum of care.

      MHCC Response: The report primarily references health care practitioners as opposed to physicians; the suggested changes to the telehealth use case application examples were made.

   c. Use case number 4 is not strictly speaking a “use case”, belongs in the finance/business model section.

      MHCC Response: Use cases are listed based on discussions in the Clinical Advisory Group (CAG) and were voted on by CAG participants.

   d. Ensure examples listed for telehealth deployment in schools are not listed as exhaustive since there are other applications.

      MHCC Response: The use case was updated to reflect that the applications listed are among other things.

   e. Terminology may feed misperceptions that use of telehealth requires an overarching system.

      MHCC Response: The report discusses how use of telehealth integrated with other health information technologies can provide the needed infrastructure.

   f. Non-medical therapeutic services (e.g., mental health counseling) and non-clinical services (e.g. occupational therapy) should be listed as part of telehealth.

      MHCC Response: Non-medical therapeutic services and non-clinical services were added.

   g. Use a dentistry example for use case 10; does the funding for the telehealth pilots include staff training and development of organizational systems.

      MHCC Response: Dentistry example added for use case application example #10.

h. Does the funding for the telehealth pilots include staff training and development of organizational systems.

MHCC Response: Details regarding use of the funding will be established as part of the grant application and award process, in collaboration with the Telemedicine Task Force.

2) Anna Aycock: The Maryland Institute for Emergency Medical Services Systems (MIEMSS) has completed an internal review of the *Telemedicine Task Force Report* and respectfully requests modification with the verbiage in items #5 and #10 discussed in the Telehealth Use Cases section within the report.

a. As originally drafted, Item #5 conveys a scenario for treatment of a stroke patient that fails to account for the system of pre-hospital care for stroke patients that has been operational in Maryland for many years. Item #5 does not accurately portray the current practices and protocols of emergency medical service (EMS) providers treating stroke patients in the pre-hospital phase of care, and its suggested application of telemedicine does not evidence integration with those practices and protocols. If applied in the pre-hospital phase as suggested in the draft, the application would be at such variance with existing EMS protocols and practice that the approach suggested could potentially result in delayed identification of a stroke patient in the field and delayed transport to a stroke center.

The stroke program in Maryland is very mature and the EMS field providers have had protocols in place since 2007 regarding assessing and transporting a possible stroke patient to the closest stroke center. MIEMSS recommends the proposed new application and believes it would better facilitate the future use of telemedicine in the EMS community: *An emergency medical technician uses audio video conferencing to connect to a trauma surgeon to discuss a patient's presentation of symptoms and assessment findings. The emergency medical technician performs an ultrasound at the patient's side who does not meet the trauma decision tree category. However, based on the field providers assessment of the patient, he suspects an injury, or underlying medical issue which may directly impact the patients outcome. The trauma decision tree is an established EMS Protocol for categorizing injured patients utilizing physiologic (i.e. low blood pressure, lower respirations), and anatomic (i.e penetrating injury) signs and symptoms along with mechanism of injury and co-morbid factors to determine the severity of the injury. The trauma surgeon performs a virtual exam, reviews the ultrasound, makes a tentative diagnosis, and directs the patient to the appropriate trauma center or community hospital. In this application, the trauma surgeon directed the patient to the most appropriate medical facility, accelerated the diagnostic process leading to earlier treatment and improved patient outcomes.*

MHCC Response: The telehealth use case applications are intended to be examples of the use case. The example application was updated and agreed to by MIEMSS.

b. Of even greater concern is item #10 which suggests that trauma surgeons could use telemedicine to remotely guide a general surgeon to treat a multi-trauma victim of a

crash in a community hospital. Maryland's trauma system, which is a model for the nation, is built on a foundational principle that such patients need to be treated in trauma centers where they can receive rapid, definitive, expert care. The value of trauma center treatment for trauma patients is well-established in the medical literature, and improved patient outcome at trauma centers has been a driving force in the development of trauma centers and trauma systems throughout the country.

The trauma program in Maryland is very mature. EMS protocols and the Trauma Decision Tree clearly address's the care and delivery of trauma patients to the appropriate facilities without delay. MIEMSS recommends the proposed new application and believes it would better facilitate the future use of telemedicine in assisting physicians in learning critical skills in a variety of specialties: *A Critical Care Intensivist uses audio video conferencing via ®eCARE or ®eICU with a Hospitalist to remotely guide the Hospitalist in the care of an unstable critical ICU patient. The Critical Care Intensivist provides expertise to the Hospitalist, who is able to stabilize the patient. In this application, telehealth enables timely stabilization of the patient. Ultimately, the patient is able to stay in the community facility without incurring the expense or transfer out-of-hospital risk of ground or air transport to the larger hospital and can remain in proximity of family.*

MHCC Response: The telehealth use case applications are intended to be examples of the use case. The report example application was updated to reflect a dentistry application to illustrate a broader range of practitioner applications and agreed to by MIEMSS.

3) Howard Haft: My complements to all involved in the production of this very comprehensive report. My only comment is related to use case (3). The example used in the use case has some potential technical issues. It also is somewhat limited in scope. The technical issues are: 1) the use of an acute allergic reaction - this is very close to a life threatening situation and is may be interpreted by some as inappropriate and unsafe use of telemedicine. The safer and better example would be a menu of non-life threatening conditions that can universally be accepted as safe for telemedicine visits; 2) the use of nurse evaluations is a slippery slope also. To make the use case more clear I would suggest the language of a qualified provider. This could be a physician, NP, PA or other qualified provider but it safely keeps the Nurse Practice Act out of the discussion. I have put a redlined suggestion in the attached document. The suggested language also broadens the example to general telemedicine consultations - not limiting to hospital gain sharing cases.

   MHCC Response: The telehealth use case applications are intended to be examples of the use case. The application example to use case #3 was updated per the suggestions.

4) John Kornak

   a. I reviewed the draft report and find this to be very good. I would recommend that some type of marketing plan be added to this to try and boost telehealth adoption across the state of Maryland. Since there are very little claims being submitted, this

is due to the lack of knowledge about telehealth for physicians and provider groups. If there is no marketing plan, how does MHCC expect to grow telemedicine with adoption? I think that random educational sessions may need to be sponsored via webinars to see if the concept of "telemedicine" is achievable in an organization as well as offering up random visits so that providers can see what we are all talking about.

MHCC Response: The report is reflective of the discussions of the advisory groups. The advisory groups did not focus on developing a marketing plan, and this was not included in the report.

b. Question - The report talks about the telehealth provider directory which would need $250,000 startup and annual $500,000[248] to maintain. Is this the ask of the report? If so, this would be $750,000 out of the $2 million ask dedicated to CRISP. I think that this initiative should be solely dedicated on the potential grants and not help to dump more money into CRISP. I think that with MATRC and their telehealth provider directory being available for all of their states that they support, we should be using it and helping to update this provider directory to add more Maryland sites rather than asking for $750,000 to assist CRISP in adding these features. Just my opinion.

MHCC Response: The telehealth provider directory would require about $270,000 and $60,000 to maintain annually, and any funding for the telehealth provider directory would be in addition to the $2 million requested to support use case implementation. The possibility of integrating the telehealth provider directory with MATRC was discussed in the Technology Solutions and Standards Advisory Group, although using a Maryland resource, such as CRISP, was determined to be the best implementation option.

5) Luigi Leblanc: I appreciate getting the insight on the telehealth direction the State envisions in 2015. I found the report very much in line with the direction several hospitals in the State are currently moving in and do see that there is increasing interest on the part of CCFs to connect to the hospitals for the very use cases stated in this document. I don't particularly see any items that need to be addressed in this document; however, I do feel that we're going to have to address how we electronically share behavioral health data between a PCP and behavioral health specialist during a telehealth consult. It would be beneficial if DIRECT could play a role in transmitting the CCDA during a referral and soap note from consultant.

MHCC Response: No changes to the report are required.

6) Barney Stern

a. Regarding the physician-patient relationship, the requirement that a patient agree to be treated is troublesome in some emergency circumstances – stroke, trauma, etc. Consider a relationship is established if a local healthcare provider, based on an

[248] The telehealth provider directory would require about $270,000 and $60,000 to maintain annually.

assessment of the patient's condition, deems a telehealth consultation beneficial to the management of the patient.

MHCC Response: The report describes the guidelines recommended by the State Medical Boards and the American Medical Association. A footnote was added for emergent situations when a patient is incapable of providing consent.

b. Edits to use case #5, from an emergency medical technician to an emergency department physician.

MHCC Response: The application example for use case number #5 was altered from stroke to accident trauma to better illustrate how telehealth can be used in transit to an acute care facility.

c. It seems important to me that there be some recommendations regarding sustainability. What happened to innovative solutions such as potential rate adjustments, etc. for infrastructure costs, etc?

MHCC Response: The Finance and Business Model (F&B) advisory group focused on identifying the finance and business model challenges of implementing the use cases. The F&B advisory group recommended that organizations deploying the use cases develop solutions unique to their organization and patient population to mitigate the challenges; no statewide solutions were discussed.

7) Daniel Winn

d. I think that I may not be understanding something important. I didn't realize that the change in the definition of telehealth automatically removed the need for an interactive component - whether audio, video or other. What is the purpose for that removal? Don't all of the use cases require interactivity? Does the removal of an interactive component "dumb down" the capability?

MHCC Response: The proposed definition of *telehealth* does not remove the audio-video technology option from the definition, rather it adds other technology options to be included in the definition (i.e. store-and-forward and remote monitoring), and would still include interactive audio-video technology. While the concept of additional technologies being included in the definition of *telehealth* and rationale is explained in the body of the report, a footnote has been added in the Executive Summary of the report to make this clearer in the Executive Summary section of the report.

e. In order to prevent confusion please consider editing the actual definition to include what you just stated.

MHCC Response: The Task Force explored the possibility of including specific technologies in the definition and agreed not to list technology in the definitions, as technology is evolving; the Task Force advisory groups determined that broadly referencing telecommunications would accommodate both current and new, evolving technology.

8) Teresa Zent: Good job distilling the many discussions into a succinct summary. Please see my attached proposed revisions and comments to the draft report. My proposals are meant to clarify some points that seemed a little vague and also to make a point about the lack of notice that the payors - both private sector and Medicaid - have given to providers that telehealth claims will receive reimbursement.

   f. We know that education about the State of telehealth law and practice in Maryland is a general problem. There is a general lack of awareness by providers that the reimbursement mandate for private payors exists in law in Maryland. Whether educating providers is something that can be undertaken by the State or needs to be handled by private organizations is unclear to me but acknowledging the problem as a barrier to the deployment of telehealth in the State is something this report should include.

      MHCC Response: Language was added to the report to indicate the Task Force did not evaluate awareness initiatives to inform practitioners about the availability of telehealth reimbursement. The report is reflective of the discussions of the advisory groups. The advisory groups did not focus on developing a marketing plan, and this was not included in the report.

   g. It would have been interesting to know which of Maryland Medicaid's programs generated the 2 hospital claims and which hospital it was.

      MHCC Response: Added to the report.

   h. Include language regarding how use cases will help identify aspects of telehealth deployment where challenges may continue to exist specific to certain business models or types of providers, which may warrant suggestions for statewide policy assistance in the future.

      MHCC Response: Added to the report.

   i. Appendices BB and CC identify time frames to implement and evaluate as 36 months. Why are the pilot use cases only 2 year partnerships with MHCC?

      MHCC Response: $2 million in funding for the use cases will likely not fund three year pilots; two year partnerships were determined more feasible with the amount of funding being requested.

   j. If, by the time this report is submitted to the Governor, et.al, grants have been awarded, then a description of the pilots underway would be more informative and illustrate real activity to support the request for grant funding from the General Assembly.

      MHCC Response: Additional information about the pilots is included in the report.

   k. On its own initiative, the Maryland Department of Public Safety and Correctional Services has been doing what it can to implement telehealth services subject to the budgetary constraints in its outsourced 5 year term contracts for inmate health care delivery. See its March 2013 report at:

dlslibrary.state.md.us/publications/Exec/DPSCS/SB781Ch579(2)HB1149Ch580(2)_2012.pdf

MHCC Response: No changes to the report are required.

9) Maryland Medicaid

a. Editorial changes.

MHCC Response: Accepted.

b. In the Executive Summary, can you define telehealth and/or move the definition of telehealth up in the document? Also, Medicaid does not take on this definition because we cannot reimburse for health education and we cannot reimburse for communication between providers. We can only reimburse for general consult with patient present.

MHCC Response: The definition of telehealth was inserted as a footnote earlier in the Executive Summary. Medicaid telehealth reimbursement restrictions were added throughout the report.

c. Telehealth is successful in certain situations with certain conditions; not every condition is appropriate for telehealth. Insert *appropriately* used.

MHCC Response: Inserted changed text.

d. Insert additional information regarding Medicaid reimbursement: *a telemental health program that began around 2012, and two telemedicine programs that began in calendar year 2013, one for rural access and one for stroke and cardiovascular conditions only within the Emergency Department. No providers applied for the stroke and cardiovascular programs, while only one hospital submitted two claims for the rural access program*.

MHCC Response: Inserted changed text.

e. Regarding use case #5, no increases potential for interrupted sessions

MHCC Response: Medicaid telehealth reimbursement restrictions were added throughout the report.

f. Medicaid does not currently cover home monitoring

MHCC Response: Medicaid telehealth reimbursement restrictions were added throughout the report.

g. Regarding use case #10, this is not reimbursable under Medicaid.

MHCC Response: Medicaid telehealth reimbursement restrictions were added throughout the report.

h. Insert the following italicized language: The TSS advisory group determined the use cases could be implemented with telehealth technology that currently exists and identified a barrier to telehealth diffusion as the lack of availability of information

about telehealth services *and a lack of understanding about to whom the benefits of telehealth services accrue.*

MHCC Response: Inserted changed text.

i. Insert the following italicized language: The implementation of the use cases will be structured as two-year partnerships, in which MHCC and the grantee(s) will work jointly and assess the impact of telehealth on quality of care and cost *and to assess the barriers to implementing telehealth use cases statewide*.

MHCC Response: Inserted changed text.

j. Insert the following italicized language: *If used appropriately within certain contexts*, telehealth has the potential to enhance access to health care and improve a patient's health status

MHCC Response: Inserted changed text.

k. Maryland Medicaid does not currently reimburse for activities that do not include a patient as part of the encounter, thus store-and-forward, remote monitoring, and mHealth would not be eligible.

MHCC Response: Medicaid telehealth reimbursement restrictions were added throughout the report.

l. Not sure if you want to mention EHR Incentive Program.

MHCC Response: This section of the report is referencing MHCC health IT initiatives. The State-Regulated Payor EHR Incentive Program is noted; the Maryland Medicaid EHR Incentive Program is not an MHCC initiative and thus not noted.

m. I am not sure about this: Medicare reimbursement for telehealth services is restricted to rural areas, which continues to hinder adoption.

MHCC Response: The text was changed to the following: Medicare reimbursement for telehealth services is restricted to rural areas, which ~~continues to~~ *may* hinder adoption.

n. Insertion: However, using telehealth to increase rural patient access to specialty services has been shown to be cost effective and improve patient care.

MHCC Response: Inserted changed text.

o. Insertion: Since enactment, Medicaid has not reimbursed for either option due to budget constraints.

MHCC Response: Inserted changed text.

p. With regard to the following text: This is not exactly true for Medicaid. Telemedicine providers, like all other providers, must be licensed in the State where they are providing services. If you're in Maryland and receiving a telemedicine consults from a provider in Virginia, the Virginia provider must be licenses in

Virginia, while the host provider must be licensed in Maryland. For the Virginia provider to be reimbursed, they must be enrolled in Maryland Medicaid.

The Task Force identified two impediments to telehealth diffusion that relate to physician licensing requirements: physicians rendering telehealth services to patients in Maryland must obtain a license by the Maryland Board of Physicians

<u>*MHCC Response*</u>: As currently stated, the text is factually correct. An assessment of how various payors apply the licensure requirements was not completed.

q. With regard to the following text: Are you suggesting that this be done at a national level? It seems like you would need to do this in order to change Medicare and Medicaid definitions.

Addressing the Maryland Physician-Patient Relationship Challenge

<u>*MHCC Response*</u>: This section is intended to be information only; no recommendations or suggestions are noted.

r. Insert the following italicized text: Some expansion of the definition has already occurred during the 2014 legislative session; the definition of *telemedicine* in Maryland Medical Assistance was broadened to include reimbursement of store-and-forward technology or remote patient monitoring*, but only if the budget allows for the reimbursement of these services*. *Since the expansion of this definition, Medicaid has never received financing to include these services*. The Task Force recommended the General Assembly adopt the following definition in replacement of the current definition of telemedicine*, recognizing to do so means that significant changes would need to be made to Maryland Medicaid to allow for covering these services.*

<u>*MHCC Response*</u>: Inserted changed text.

s. Medicaid currently does not cover education and other items mentioned previously.

<u>*MHCC Response*</u>: Medicaid telehealth reimbursement restrictions were added throughout the report.

t. With regard to the following text: Not Medicaid.

Remote mentoring, monitoring, and proctoring for the expansion, dispersion, and maintenance of skills, supervision, and education

<u>*MHCC Response*</u>: Medicaid telehealth reimbursement restrictions were added throughout the report.

u. With regard to the following text: Very, very true. This point should definitely be made in the executive summary. Until this point, the document reads as if we can easily move forward with these use cases and implement them with barely any challenges. This is a huge challenge to sustainability.

The F&B advisory group emphasized that organizations deploying the use cases need to develop solutions unique to their organization and patient population to mitigate

the challenges. Absent addressing the financial and business model challenges, sustainability of the use cases is unlikely when funding, such as grants or venture capital, is depleted.

MHCC Response: Similar language was added to the Executive Summary.

v. With regard to the following text: As defined by?

underserved population areas and/or rural areas

MHCC Response: The law that initiated the Task Force included the language *underserved population areas and/or rural areas*. The Clinical Advisory Group contemplated the definitions and concluded to leave the definition of the terms open ended.

w. Regarding the telemental health claims received by Medicaid in 2013 (75 for 2013), the number cited in the report is far too low (see page 8). In FY12, the Department received an average of 519 telemental health claims each month resulting in more than 8,000 claims over the course of the fiscal year. With coverage now expanding to include all counties statewide, we anticipate receiving significantly more claims in FY15.

MHCC Response: Telemental health data were updated in the report.

x. As you know, the regulations governing the reimbursement of telemedicine services provided by Medicaid are changing. The appendices should be updated to reflect the new regulations.

MHCC Response: Draft Medicaid regulations were added to the appendix of the report.

y. Although SB 198 granted the Department the authority to reimburse for store-and-forward and remote patient monitoring claims, our proposed regulations continue to be structured around reimbursement for originating sites and consulting sites only. While the report acknowledges that coverage of store-and-forward and patient monitoring services is subject to budget limitations, it should be revised to better reflect what will be covered under the proposed regulations rather than what is permissible under SB 198. Given the expanded definition of telehealth adopted by the Task Force, making this nuance clear is important.

MHCC Response: The report was updated to reflect that regulations define reimbursable services by Medicaid.

z. I continue to be concerned that the proposed use cases are too broad and abstract as drafted. While developing a statewide policy addressing all potential financial and business model challenges of deploying the use cases may not be feasible (p. 17), there are some additional overarching concerns that could be captured here. For example, payers and providers should want to reduce or minimize the technology costs associated telehealth. It is also critically important that any systems implemented are interoperable. In keeping with these principles, one suggestion

discussed in the workgroups that warrants further consideration is encouraging hospital providers to develop centers of excellence around telemedicine technology, for example, facilities with expertise in cardiac and neurological conditions.

MHCC Response: The centers of excellence are included in the F&B advisory group documents in the appendix.

Appendix KK: Announcement for Telehealth Pilot Grant Applications

The Maryland Health Care Commission issued the following announcement for grant applications to implement telehealth pilot projects where telehealth technology is used to demonstrate an impact in transitions of care between a comprehensive care facility (CCF)[249] and a general acute care hospital in Maryland.

Begin quoted text

Center for Health Information Technology & Innovative Care Delivery

Announcement for Grant Applications

Grant ID Number: **MHCC 15-001**

Issue Date: **August 18, 2014**

Title: **Long-Term Care/Hospital Telehealth Pilot**

Purpose

Maryland law[250] authorizes the Maryland Health Care Commission (MHCC) to award grants. In accordance with State law, the MHCC, in conjunction with the Maryland Health Quality and Cost Council, reconvened the Telemedicine Task Force (Task Force) to identify opportunities to expand the use of telemedicine to improve health status and care delivery throughout the State.[251] The Task Force is developing legislative recommendations regarding telehealth use case categories, supported by existing technologies and facilitated by a telehealth provider directory.

The MHCC intends to award a grant up to $30,000 where telehealth[252] technology will be used to demonstrate an impact in transitions of care between a comprehensive care facility (CCF)[253] and a general acute care hospital in Maryland. The pilot will use telehealth technology and assess its impact on hospital emergency room visits, admissions, and readmissions from a CCF to a general acute care hospital. The awardee will be required to use an electronic health record (EHR) and services of the State-designated health information exchange (HIE), the Chesapeake Regional Information System for our Patients (CRISP).[254] The awardee will report on the impact of telehealth on select clinical goals.

Requirements

The awardee will implement a nine-month pilot that includes the following entities: (1) a general acute care hospital; (2) a CCF; and (3) a telehealth technology vendor. The applicant must identify the prime recipient of the grant award and the participating organizations that, combined, form the applicant. Any of the required entities could be the applicant. The goal of the grant is to demonstrate the impact(s) of using telehealth technology to improve transitions of care between a

[249] The term in Maryland law for a nursing home, sometimes also known as a Medicare skilled nursing facility (SNF).
[250] Md. Code Ann., Health-Gen. §19-109 (2014).
[251] Senate Bill 776, *Telemedicine Task Force – Maryland Health Care Commission*, (Chapter 319, 2013 Regular Session). Available at: mgaleg.maryland.gov/2013RS/chapters_noln/Ch_319_sb0776E.pdf.
[252] Telehealth is the delivery of health education and services using telecommunications and related technologies in coordination with a health care professional.
[253] The term in Maryland law for a nursing home, sometimes also known as a Medicare skilled nursing facility (SNF).
[254] Additional information about CRISP is available online here: crisphealth.org.

CCF and a general acute care hospital. The CCF and general acute care hospital must use CRISP services, including the encounter notification service (ENS) and query portal. The awardee will be required to submit a report[255] at the conclusion of the grant that assesses the pilot and describes the results of the pilot from the perspectives of both the participating hospital and the participating CCF. The report should document the lessons learned and assess the feasibility of the hospital and the CCF continuing the telehealth program after the pilot period.

A. Tasks

To be considered for a grant award, an applicant is required to:

1. Propose a telehealth technology use case that meets the following requirements:
    a. Reduce hospital emergency room visits, admissions, and readmissions from the CCF;
    b. Improve transitions of care between a CCF and a general acute care hospital by reducing hospital readmissions;
    c. Expand clinical expertise available at the CCF; and
    d. Describe how the pilot will maximize the use of telehealth, CRISP (and any other HIEs), and EHRs.
2. Secure a 1:1 financial match with a maximum of 20 percent of the match being in-kind technical professional hours provided by information technology staff or consultants. Clinical care hours attributed to work on the pilot are excluded from contribution to the match.
3. Using the following table as an example, identify at least three clinical goals of the pilot that can be evaluated pre- and post-implementation of telehealth technology. The quality measures should be clear and verifiable, and tied to a project objective, with monthly milestones. The goals must:
    a. Include measure(s), key definitions for all terms of each measure, and a baseline definition (see below table for format); and
    b. Include a numerator and denominator, and identify of how the numerator and denominator will be calculated.

Clinical Goals		
Measure *EXAMPLE*	**Key Definitions** *EXAMPLE*	**Mechanism to Measure** *EXAMPLE*
Percent change in hospital readmission rates for patients discharged from a general acute care hospital to the CCF *Suggested Denominator*: Total number of patients discharged from	**Hospitalization:** Transfer of a CCF resident to any general acute care hospital **Hospital Readmissions:** *Readmissions*: 1: Readmissions in the current	**Denominator**: How the pilot participants plan to calculate the denominator (for example, calculated on a daily basis through EHR at the CCF by quality assurance nurse and then

[255] Length not to exceed ten content pages.

Clinical Goals		
Measure *EXAMPLE*	**Key Definitions** *EXAMPLE*	**Mechanism to Measure** *EXAMPLE*
a general acute care hospital to the CCF within a month *Suggested Numerator*: Number of CCF patients readmitted for the same or related condition to a general acute care hospital within a month *Percent Change*: A month performance period minus a month base line performance period from the previous year	month for the same or related condition to any acute care hospital 2: Readmissions in the pilot nine month period *Baseline***:** 1. Readmissions in the same month in the prior year. The prior month refers to the same month in the prior year to the start of the pilot 2. Readmissions in the same nine month one year previous	totaled for each quarter) **Numerator**: How the pilot participants plan to calculate the numerator (for example, calculated on a daily basis through the EHR at the CCF by nurse and then totaled for each quarter)

Key tasks following an award:

1. Submit a final report (not to exceeded 10 pages) at the conclusion of the grant that includes:
    a. Description of the technology infrastructure used at the hospital and CCF, including EHRs, HIE, and telehealth equipment;
    b. Lessons learned;
    c. Pilot implementation challenges, both expected and unexpected, how these challenges were addressed, and whether or not they were mitigated;
    d. Cost effectiveness of implementation strategies;
    e. Results of the assessment;
    f. Sustainability prospects;
    g. Additional other metric(s) that may be valuable to the assessment; and
    h. Recommendations for continuation or replication of the pilot.
2. Throughout the duration of the grant award:
    a. Participate in bi-weekly update conference calls with pilot participants and MHCC; and
    b. Submit monthly reimbursement requests along with supporting documentation, and an update on the progress of making use of telehealth technology and achieving the clinical goals, which will serve as an audit trail for both the grant award and matching funds that will be tied to the awardee's achievement of all measurable goals.

The MHCC and the awardee must agree on all activities specific to each task prior to the awardee's performance of the work, and MHCC will determine whether a task is satisfactorily complete before the task will be considered complete for payment.

B. Required Qualifications

The applicant must have experience in telehealth and HIE deployment. The ideal applicant will have experience deploying health information technology in CCFs. The applicant must include a letter(s) of support from each participant organization(s) that summarizes activities planned for the pilot for each of the grant participants and commitment to complete the work within the pilot project plan timeline.

C. Grant TASKS & Due Dates

Grant Tasks	Due Date
Participate in bi-weekly status conference calls with pilot partners and MHCC	Ongoing
Submit monthly update on the progress of making use of telehealth technology and achieving the clinical goals	By fifth business day of following month
Submit monthly reimbursement requests	By 15th day of following month
Draft project plan and kick-off meeting	9/26/14
Final project plan	10/3/14
LTC telehealth use case pilot	
Draft of the clinical quality measures	10/10/14
Begin implementing the pilot	10/15/14
Conclude implementation of the pilot	7/31/15
Final Report – Sections due to MHCC	
Outline	
Draft	6/1/15
Final	6/15/15
Description of the technology infrastructure used at the hospital and CCF including all EHRS, HIE, and telehealth equipment	
Draft	6/19/15
Final	6/26/15
Lessons learned, and pilot implementation challenges	
Draft	7/10/15
Final	7/25/15
Cost effectiveness and sustainability prospects	
Draft	7/15/15
Final	7/29/15
Results of the Final Report and recommendations for replication	
Draft	7/31/15
Final	8/15/15
Compiled report final draft	8/15/15

Note: Grant tasks/due dates are tentative and subject to change at the discretion of MHCC, after discussion with the awardee, and are not listed within the table in any particular order.

D. Staffing and Personnel Requirements

An applicant may propose to augment or revise the following list of required personnel.

Labor Categories	Description
Project Director	A senior level individual that will coordinate all aspects of the work, and take responsibility for meeting the schedule of tasks.
Technical Manager	A management level individual with experience in managing technology deployment that can ensure staff training and utilization of the technology among all participants.
Clinical Consultant	A licensed health care practitioner that will work on the pilot, using the telehealth technology, and provide consultation to the Technical Manager to increase the effectiveness of the use of telehealth technology and redesign clinical processes.

E. Term of GRANT

The grant begins on or about **September 26, 2014** and will end **August 30, 2015**. Awardee submission of reimbursement requests is required by the 15th of the month for the prior month and must include a description of the completed tasks in accordance with the Task Schedule in Section II, as well as supporting documentation for requested funds and match contribution. The supporting documentation must be of a quality that will withstand an audit. All tasks and work performed, and all reimbursement request documentation included must be to the satisfaction of MHCC for reimbursement approval.

If it becomes necessary to revise this announcement for grant applications before the due date for applications, amendments will be announced on the MHCC website. Multiple and/or alternate applications will not be accepted. The MHCC will not be responsible for any costs incurred by an applicant in preparing and submitting an application or in performing any other activities relative to this grant notification. The MHCC reserves the right to cancel this announcement for grant applications, accept or reject any and all applications (in whole or in part) received in response to this announcement for grant applications, to waive or permit cure of minor irregularities, and to conduct discussions with all qualified or potentially qualified grant applicants in any manner necessary to serve the best interests of the MHCC and accomplish the goals of this grant announcement.

Before an entity can do business in the State it must be registered with the Department of Assessments and Taxation, State Office Building, Room 803, 301 West Preston Street, Baltimore, Maryland 21201. It is strongly recommended that any potential applicant complete registration prior to the due date for receipt of applications.

F. HOW TO APPLY

An applicant submitting a grant application must follow the requirements detailed below. Grant applications are due to MHCC by 5:00 p.m. Eastern on **Friday, September 5, 2014**. Applications must be submitted via email to sarah.orth@maryland.gov.

All questions regarding this announcement for grant applications should be submitted via email to sarah.orth@maryland.gov; all questions and responses will be posted on the MHCC website.

G. REQUIREMENTS FOR APPLICATION

An application must be prepared in a clear and precise manner and address all requested items, as described below, in 15 or fewer pages. Original and creative approaches to using telehealth are encouraged. The application MUST contain the following sections:

1. *Cover page*: A completed template cover page in Attachment A to this announcement.
2. *Scope of work*:
    a. Executive Summary. A half-page overview of the purpose of your organization's application, summarizing the key points.
    b. Statement of the Problem. Clearly state the problem that needs to be solved and the objective of the proposed telehealth initiative. Please limit to one page.
    c. Scope of work and strategy. This section should describe the proposed telehealth project. Address the requirements for each task and describe how the proposed services, including the services of any proposed sub-awardee(s), will meet or exceed the requirement(s). Include a concise and detailed description of the scope, breadth, and plans/approach for completing each task described in Requirements (Section IIA, above), including how the applicant plans to complete the tasks to the highest level of quality and in a timely manner.

        The application should be structured using the sections detailed below. Where relevant, technical architecture and clinical workflow diagrams should be used to depict the proposed telehealth pilot. Information submitted in the Appendices should be specific to support the application, and not simply technical brochures. Material in the Appendices is not included in the total page count. MHCC may request additional material, if needed for clarification, during evaluation of grant applications.

        i. Project Description

            a) What will the pilot do? What is the overarching purpose of the pilot? What are the key programmatic components of the project? Quite literally, who will do what for whom, with whom, where, and when?

            b) What will be the benefits and measurements of success? If the pilot is successful, what visible, tangible, objectively verifiable results will you be able to report at the end of the pilot? What longer-term benefits do

you expect for the target population and the broader community? What is the envisioned benefit of implementing telehealth technology?

c) How will the pilot be sustained after grant support ends? Will the pilot require ongoing outside support after the proposed grant ends? If plans are not yet firm, what process will you employ to work towards sustainability?

d) Describe the demographics of the CCF and the general acute hospital. What size is the CCF? Describe current general hospital admission and readmission rates for CCF residents. Identify the health conditions responsible for most hospitalizations from the CCF. Explain the current relationship between the hospital and the CCF and the expected impact of the telehealth pilot. What is the payor mix of the CCF?

ii. Work Plan

a) What is the timeline for accomplishing specified tasks? Prepare a Gantt chart or other timeline listing project tasks and the time period over which these tasks will be undertaken. The work plan chart may be attached as an appendix item to the application.

b) The specific methodology and techniques to be used in executing the tasks should be included in this section.

d. *Applicant qualifications*: Describe the qualifications of the organization(s) that will be participating in the tasks under the grant, including each organization's experience in performing similar work and, if applicable, work performed specifically related to assessing, developing, and managing telehealth. The applicant must demonstrate how it meets the qualifications requirements in Section IIB, above. Please limit to one page.

e. *Experience and qualifications of the proposed staff*: Describe the experience and qualifications of the proposed staff in performing similar work and, if applicable, work performed specifically related to telehealth. The grant applicant must demonstrate how its proposed staffing model meets the staffing requirements and required personnel described in Section IID, above, and, if applicable, as augmented by the applicant. Other essential staff, their roles in the pilot, and their relevant qualifications should be identified. Please limit to one page.

3. *Additional documentation*: An applicant must include as an appendix (appendices are not included in the Scope of Work page count) to the application an individual resume or detailed biography for each of the personnel who will be assigned if the applicant is awarded the grant. Sub-awardees, if any, must be identified, and a detailed description of their contributing role(s) relative to the requirements must also be included in the application. Each resume or biography must include the amount of experience the individual has completed of the type of work and tasks detailed in this grant announcement.

4. *Financial proposal*: The financial proposal must include the costs of equipment proposed under the grant and the fully-loaded hourly rate for the work to be performed. Include an estimate of the total number of hours required to complete each task. Submit a budget for both award funds and matching funds using Attachment B. The financial proposal attachment is not included in the Scope of Work page count.
5. *Letters of commitment*: Letters of intended commitment to work on the project from personnel from each organization must also be included as an appendix (appendices are not included in the Scope of Work page count) to the application. The letters of commitment should contain a brief description (approximately one paragraph) of the work to be performed for the pilot by that organization.
6. *Disclosure*: An applicant must disclose any substandard quality of care level deficiencies, CMS admissions ban, and note any outstanding health and safety violations.

H. TERMINATION CLAUSE

The State of Maryland may terminate this grant award at any time and for any reason. An applicant must acknowledge this statement in its application for its response to be considered acceptable.

MINORITY BUSINESS ENTERPRISES AND SMALL BUSINESSES

ARE ENCOURAGED TO RESPOND TO THIS GRANT ANNOUNCEMENT

Attachment A: Application Cover Page

Applicant Organization

Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ County: _____
Federal Tax ID Number: _____

Official Authorized to Execute Contracts

Name: _____ Title: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Project Director (or alternative staffing model)

Name: _____ Title: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Technical Manager (or alternative staffing model)

Name: _____ Title: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Clinical Consultant (or alternative staffing model)

Name: _____ Title: _____

Email: _____ Phone: _____

Signature: _____ Date: _____

Grant Request

Project Title: _____

Amount Requested: $_____ Match Contribution: $_____

Attachment B: Financial Proposal

Organization Name: _____

Project Name: _____

Revenues	**Dollar Amount**	**Percent of Total Project Cost**
MHCC Grant Request		
Organization Match		
Other Grant/Funding Request		
Total Project Cost		

Budget Request	**Dollar Amount**	**Unit Cost**	**Identify Match or Grant Funds**
Staff			
% FTE, Name, Title			
% FTE, Name, Title			
% FTE, Name, Title			
Item *(specify)*			
Item *(specify)*			
Item *(specify)*			
Item *(specify)*			
Item *(specify)*			
Item *(specify)*			
** Insert additional rows as needed*			
Total			

End quoted text

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