Statement of the Rural Maryland Council and Maryland Rural Health Association to the House Health and Government Operations Committee
January 20, 2011

House Bill 14: Health Insurance - Medically Underserved Areas and Populations - Reimbursement for Covered Services Rendered by Telemedicine

House Bill 16: Task Force to Study the Use of Telemedicine in Medically Underserved Populations and Areas

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The Rural Maryland Council (RMC) is an independent state agency and the state's federally designated State Rural Development Council under the USDA's National Rural Development Partnership. Our charge is to identify challenges common to rural communities and to help craft solutions in a collaborative manner. Improving access to affordable quality health care for rural and underserved citizens of Maryland is the RMC's top strategic focus.

The Maryland Rural Health Association (MRHA) is a non-profit member organization whose mission is to educate and advocate for the optimal health of rural communities and their residents. Membership includes rural health departments; hospitals; community health centers; and individual rural Marylanders.

Most areas in Maryland suffer from a healthcare work force shortage; however, the shortages in rural Maryland are the most severe and will be worse with time unless significant, even profound, steps are taken to address them. Rural regions struggle to recruit drastically needed primary care physicians and have little hope of recruiting limited specialists. The Rural Maryland Council (RMC) and the Maryland Rural Health Association (MRHA) have been studying the potential of telehealth/telemedicine (THTM) to address health care workforce shortages and improve access to care for more than two years. We are convinced that a robust telehealth network that connects our world class urban and suburban medical institutions with the rural and underserved areas in our state would improve access to quality care in a cost effective delivery mechanism for our most vulnerable citizens.

During the past year, the RMC and the MRHA conducted a survey of telehealth projects currently underway in the state in hopes we could find ways to use that technology more effectively in rural areas. The inventory of projects was funded through the Maryland Agricultural Education and Rural Development Assistance Fund (MAERDAF). The survey targeted 95 facilities, which included all Maryland hospitals, Federally Qualified Health Centers, individual departments within the University of Maryland Medical System, The Johns Hopkins Health System and MedStar Health, as well as local health departments, state correctional institutions, and projects within Maryland Department of Health and Mental Hygiene.

Of this group, 30 facilities representing 53 different Telehealth/Telemedicine clinical sites responded. Virtually every survey respondent indicated that their top priority for service continuation and expansion is a need for reimbursement by state Medicaid and other third-party payers.

Those currently using technology to provide clinical services around the state are not being reimbursed. Rather, costs are either being paid for on a fee-for-service basis, by specific grants or being absorbed by the participating facilities. This model is unsustainable over the long term and infrastructure now being invested in will be lost without an ongoing funding stream. TMTH programs funded from time-limited federal funds in our rural regions

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will cease to provide child psychiatrists, dermatologists, nurses, speech therapists, and cardiologists to patients in need unless all carriers in the state reimburses for these services. With reimbursement increased and diversified, urban-centered specialists -- such as neurologists, genetic counselors, and orthopedics -- can start to reach underserved populations. In 2010, Virginia became the 12th state to mandate private health plans to cover THTM. Even without mandates overall, 26 states have private payers reimbursing for TMTH, but Maryland is not one of them.

Maryland is one of only 18 states that Medicaid does not reimburse for the provision of THTM services. In 2006, 27 states had Medicaid policies regarding the reimbursement of TMTH; today, at least 32 states have Medicaid reimbursing policies. Medicare has been reimbursing telemedicine services nationally since 1997 in rural Health Professional Shortage Areas.

The RMC and MRHA strongly encourage the establishment of a statewide telehealth/telemedicine network to be an integral part of the state's effort to address the health care work force shortage. Adequate and fair reimbursement by both Medicaid and private insurers is a necessary component of the long-term success of that network. According to the California Telemedicine and eHealth Center, improved outcomes and cost savings have been achieved by TMTH programs to include: reduction in hospitalizations by as much as 50% by keeping patients monitored at home; re-admission rates following heart failure; reducing mortality rates by 15-30% and length of stay of patients in Intensive Care units with remote monitoring.

We recognize, however, that providing and requiring reimbursement can be an expensive and technically complex proposition for private and public payers alike, especially where different services require different types of technology and levels of expertise among providers. Definitions of what is and what isn't a telehealth and telemedicine clinical service needs to be articulated and, perhaps, codified. And we understand that regulations regarding licensing, credentialing and scope of service may be unclear to providers who have never delivered services through technological means or across state lines.

DHMH's Telemedicine Taskforce within the Health Quality and Cost Council, which was created in June 2010, has just begun looking at these issues and already has plans and procedures for conducting an extensive and comprehensive review of what is needed to establish a statewide telehealth system. The task force will report by December 2011 with next steps in policy recommendations. RMC and MRHA will assist the DHMH task force in any way possible, and we look forward to reading its complete study recommendations.

Because the DHMH task force has much work yet to do, the RMC and MRHA are not now prepared to recommend the best way to structure and phase in those reimbursements, but we strongly encourage the General Assembly to adopt a sense of urgency to establishing a THTM network and to support the goals of the current DHMH task force. The long term growth of THTM will allow all Maryland residents – both those in remote geographic areas as well as our inner cities -- to have access to the care and expertise they need, whether it is delivered by a health care provider in person or through some technological avenue. Providing THTM reimbursement must be a priority in moving this network forward within the state.

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***Attachment**: Final Report of the Rural Maryland Council – Maryland Rural Health Association Statewide Roundtable on Telehealth/Telemedicine, conducted December 6, 2010.*