RESOLUTION 11-19

Title:	Comprehensive Telemedicine Policy for Care Delivery and Access
Introduced by:	Jaya Parulekar for the Medical Student Section
Original Authors*:	Connor Buechler, Raymond Chung, Jessica Johns, Vikas Kanneganti, and Amanda Manly
Referred to:	Reference Committee A
House Action:	**APPROVED AS SUBSTITUTED**

Whereas, telemedicine technologies have promise for delivering and increasing access to quality health care, and

Whereas, telemedicine is effective across many populations (adult, child, geriatric, and ethnic), and in many settings (emergency and home health) and increases access to care, with assessment and treatment outcomes equivalent to in-person care, including decreased hospitalizations and readmissions, and

Whereas, telemedicine programs have been shown to provide effective treatment of psychiatric issues and a reduction in emergency and urgent-care visits without a decline in quality, and

Whereas, the scope of telemedicine services eligible for reimbursement was expanded in 2018 for Medicare patients, and

Whereas, Medicaid, in addition to many private insurers, reimburses telemedicine sessions, up to and including video consultations, in 48 states, including Michigan, and

Whereas, legislation enhancing existing laws, or otherwise promoting telemedicine, was passed in many states in 2018, and

Whereas, Michigan Medicaid policies require the patient to already be in a clinical setting (e.g., clinic, hospital, or skilled nursing facility) for the session to be reimbursable, which negates the ability of telemedicine to overcome many barriers to care, and

Whereas, the Centers for Medicare and Medicaid Services, which oversees Medicare and Medicaid at the federal level, cites lack of coverage for telehealth services to patients not located at particular originating sites as one of the key barriers preventing expansion of telehealth services, and

Whereas, thirteen states have adjusted their Medicaid policies to permit a patient's home to be an originating site since 2016, and

Whereas, the American Medical Association (AMA) has policy, H-210.981, recognizing the value of telemedicine in provision of care within a patient's own home, and

Whereas, our AMA has policy, H-480.974, recognizing its role in evaluating legislation regarding telemedicine, and

Whereas, our AMA adopted the Code of Medical Ethics Opinion Number 1.2.12 – Ethical Practice in Telemedicine; therefore be it

RESOLVED: That MSMS supports the use of telemedicine pursuant to applicable standards of care and shall develop policy regarding the ethical practice of telemedicine and improved access through the elimination of barriers, including but not limited to, restrictive originating site requirements and fees.

WAYS AND MEANS COMMITTEE FISCAL NOTE: $1,000 or more for costs related to the adoption of new or revised MSMS or AMA policy.

Relevant MSMS Policy: None

Relevant AMA Policy:

On-Site Physician Home Health Care H-210.981
Our AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or detrimental to the patient's health.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, severity of illness, and socioeconomic status.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.

Evolving Impact of Telemedicine H-480.974
Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;

(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.

Sources:

1. State Telehealth Laws and Reimbursement Policies. The Center for Connected Health Policy. 2018. Available at: https://www.cchpca.org/sites/default/files/2018-10/CCHP_50_State_Report_Fall_2018.pdf [Accessed 25 Feb. 2019].
2. Medicaid Provider Manual. Michigan Department of Health and Human Services. 2019. Available at: https://www.mdch.state.mi.us/dch-medicaid/manuals/MedicaidProviderManual.pdf [Accessed 25 Feb. 2019].
3. Syed S, Gerber B and Sharp L. Traveling Towards Disease: Transportation Barriers to Health Care Access. Journal of Community Health. 2019;38(5), 976-993.
4. Sorkin D, Murphy M, Nguyen H and Biegler K. (2019). Barriers to Mental Health Care for an Ethnically and Racially Diverse Sample of Older Adults. Journal of the American Geriatric Society. 2019;64(10), 2138-2143.
5. Centers for Medicare & Medicaid Services. Information On Medicare Telehealth. U.S. Department of Health and Human Services; 2018. Available at: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Information-on-Medicare-Telehealth-Report.pdf. [Accessed 25 Feb. 2019]
6. Hilty D, Yellowlees P, Parrish M, Chan S. Telepsychiatry: Effective, Evidence-Based, and at a Tipping Point in Health Care Delivery. Psychiatric Clinics. 2015;38(3), 559-592.
7. Hubley S, Lynch S, Schneck C, Thomas M, Shore J. Review of key Telepsychiatry outcomes. World Journal of Psychiatry. 2019;6(2), 269.
8. Hilty D, Ferrer D, Parish M, Johnston B, Callahan E, Yellowlees P. The Effectiveness of Telemental Health: A 2013 Review. Telemedicine and E-Health Journal. 2013;19(6), 444-454.
9. McGinty KL, Saeed SA, Simmons SC, Yildirim Y. Telepsychiatry and e-mental health services: potential for improving access to mental health care. Psychiatric Quarterly. 2006;77(4), 335-342.
10. Fortney J, Pyne J, Turner E, Farris K, Normoyle T, Avery M. Telepsychiatry integration of mental health services into rural primary care settings. Taylor & Francis. http://www.tandfonline.com/doi/abs/10.3109/09540261.2015.1085838. Published 2015. Accessed February 25, 2019.
11. Norman, S. The use of telemedicine in psychiatry. J Psychiatr Ment Health Nurs. 2006;13(6):771-777.
12. Chung-Do J, Helm S, Fukuda M, Alicata D, Nishimura S, Else I. Rural mental health: implications for telepsychiatry in clinical service, workforce development, and organizational capacity. Telemedicine and e-Health. 2012;18(3), 244-246.
13. Fortney JC, Pyne JM, Mouden SB, et al. Practice-based versus telemedicine-based collaborative care for depression in rural federally qualified health centers: a pragmatic randomized comparative effectiveness trial. American Journal of Psychiatry. 2013;170(4), 414-425.
14. Fryers TE. Social inequalities and the common mental disorders: a systematic review of the evidence. Social Psychiatry and Psychiatric Epidemiology. 2003;38(5), 229-237.
15. The Role of Medicaid for People with Behavioral Health Conditions. Kaiser Family Foundation. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_bhc.pdf. [Accessed February 25, 2019.]
16. Lambert H. The underutilization of mental health services in an ethnically and racially diverse, predominantly low-income population: An investigation of worldview. ETD collection for University of Nebraska - Lincoln. 2003. Available at: http://digitalcommons.unl.edu/dissertations/AAI3102569/. [Accessed February 25, 2019.]
17. Doherty AM, Gaughran F. The interface of physical and mental health. Social Psychiatry and Psychiatric Epidemiology. 2014;49(5), 673-682.
18. Lokkerbol J, Adema D, Cuijpers P et al. Improving the Cost-Effectiveness\
19. Early Experience with Technology-Based Eye Care Services (TECS): A Novel Ophthalmologic Telemedicine Initiative. Ophthalmology. 2017 Apr;124(4):539-546.
20. https://www.aao.org/clinical-statement/telemedicine-ophthalmology-information-statement
21. https://www.aoa.org/Documents/Legal/Position%20Statement%20Regarding%20Eye%20and%20Vision%20Telehealth%20
22. Services%20-%20Referenced%20in%20HOD%20Resolution%201989.pdf
23. https://www.telehealthresourcecenter.org/2018-in-review-state-federal-telehealth-policy/

*Lakshmi Guduguntla, Nousha Hefzi, Yusra Oral, Anneliese Petersen, and Anita Ukani also contributed.