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TELEMEDICINE UPDATE AND NEXT STEPS

2015 BROADBAND SUMMIT

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Telemedicine Adoption is Tipping

- American Telemedicine Association defines telemedicine as "the use of medical information exchanged from one site to another via electronic communications to improve a patient's clinical health status.
- Originally focused to accessing specialty care for patients in remote and underserved areas,
- Telemedicine has grown rapidly
  - Includes a applications and technologies deployed across entire patient care continuum in both rural and urban markets.

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Telemedicine Barriers

- Legal
  - Rules/Mandates—local and national policymakers
  - Licensure across state lines
- Regulatory
  - Public sector Place/Type Rules—Medicare and Medicaid
- Financial
  - Costs—equipment, connectivity, staff support
  - Limited reimbursement
- Technological
  - Equipment, bandwidth, security and privacy
- Cultural
  - Differing degrees of acceptance clinical, administrative, payer and technical communities

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Example Telemedicine Parity Law

- AZ SB1353 provides parity of payment for a telemedicine service if
  - After 1/1/2015
  - Insured person lives in "rural" AZ
  - Service Provider complies with AZ licensure, accreditation standards, and practice guidelines.
  - Service is within the SB1353 enumerated list:
    - Trauma, Burn, Cardiology, Infectious Diseases, Mental Health Disorders, Neurologic Diseases—including Strokes, and Dermatology

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Looking Forward—Legal Hurdles

- State and federal Regulators continue evaluating the Tele-healthcare delivery model
  - Multi-State Licensure
  - Establishing a doctor-patient relationship
  - Supervision
  - Corporate practice of medicine
  - FDA-Devices

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Interstate Medical Licensure Compact Gains Approval

- 16 U.S. Senators
  - Endorsed Compact concept to increase multi-state practice and telemedicine
- 25 state medical/osteopathic boards
  - Including American Medical Association
- 13 states formally introduced legislation
  - Illinois, Iowa, Maryland, Minnesota, Montana, Nebraska, Oklahoma, South Dakota, Texas, Utah, Vermont, West Virginia and Wyoming
- 3-State legislatives have passed the Interstate Medical Licensure Compact
  - South Dakota, Utah, and Wyoming

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Multi-State Licensure—Portability Federation of State Medical Boards Model

- Basic Notion--FSMB generated a "model" that
  - Member states could codify in statute
  - Allow member states to leverage FSMB as negotiation agent with Congress
  - Preserve traditional state jurisdiction to the extent practicable
- FSMB joined with Council of State Governments (CSG) to carve out a "pathway for licensure"--that
  - Would "not otherwise change a state's existing medical practice act"
  - Would "offer an expedited licensure process for physicians"
  - Would not preclude physicians who do not meet the model-standards from obtaining licensure in multiple states through traditional processes
  - Would not
    - "compromise existing fee structures"
    - "affect ability of state medical boards to assess fees"
    - "frustrate ability to fund investigations" or
    - "affect state disciplinary process"

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License Portability
FSMB Model

Model Compact licensure process

- Physician designates a "**home state**," which is
  - (1) state of primary residence
  - (2) state where at least 25% of medical practice occurs, or
  - (3) if no state qualifies under (1) or (2), location of employer.
- Physician files application for expedited licensure with home state board of medicine
- Physician completes registration process established by Interstate Medical Licensure Compact Commission
- Physician pays fees required by board of medicine of "**participating state**" and Commission
- Board of medicine of participating state
  - Verifies eligibility
  - Receives fees
  - Issues physician a license to practice in participating state.

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Establishing the Doctor-Patient Relationship

- Traditional View
  - Some states require an "in-person" (face-to-face) consultation between physician and patient to form doctor-patient relationship.
- Modern Trend—and AZ
  - Allow a medical history be conducted remotely if the technology is sufficient to provide the same information to the physician as if the exam was performed face to face.
- Once a physician affirmatively acts in a patient's case by examining, diagnosing, treating, or agreeing to do so and patient accepts, relationship exists (no in-person presence requirement in historic case law)

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Supervision

- ISSUE: Physician supervision of personnel providing healthcare services or procedures
  - "General Supervision"
    - Procedure under physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.
  - "Direct Supervision"
    - Physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure.
  - "Personal Supervision"
    - Physician must be in attendance in room during performance of procedure.

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Corporate Practice of Medicine

- Traditional View
  - Long-standing doctrine restricting non-professionals and non-professional entities from practicing medicine or employing professionals to practice medicine.
- Modern Trend
  - Non-professional entities may assist professional entities with a telemedicine business by serving as its manager—allowing licensed professionals to focus on practice of medicine.

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FDA Cybersecurity Guidelines for Connected Medical Devices

- Why is all this important?
  - Centers for Disease Control and Prevention estimates
    - 35 million hospital discharges
    - 100 million hospital outpatient visits
    - 900 million physician office visits
    - Billions of prescriptions.
  - Most encounters include a networked medical device
    - FDA is taking a proactive approach to the cybersecurity of internet connected medical devices.
  - Devices contain computer systems
    - Often wirelessly connected with hospital/clinic legacy systems
    - often are entry points into legacy systems for cyber criminals.

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Thank You

- Questions?

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