Maryland Telehealth and Telemedicine (THTM) Survey
Interim Report: September 2010
A project of the Rural Maryland Council, Maryland Rural Health Association and Upper Shore Regional Council

Background: The *2007 Maryland Rural Health Plan*, released by the State Office of Rural Health (SORH), identified access to primary and specialty care as the top priority for ensuring quality care in rural Maryland. In 2008, the Rural Maryland Council (RMC) and SORH conducted a Rural Health Roundtable to determine actions the RMC could take to help implement at least a portion of the plan. One of the many recommendations to emerge from that event was to create a statewide telehealth consortium that would help those delivering and receiving telehealth/telemedicine (THTM) services to use technology more widely and cost effectively to deliver care across the state. In addition, the 2008 Task Force to Review Physician Shortages in Rural Areas, chaired by Senator Thomas "Mac" Middleton, recommended exploring how THTM could be used to reduce barriers to access and how reimbursement mechanisms could be implemented.

Early in 2009, the RMC and SORH held a statewide Telehealth Roundtable that concluded that a statewide inventory of current THTM projects needed to be undertaken to better understand what the state of THTM was in Maryland before moving forward with a consortium. In 2010, the Upper Shore Regional Council, an active participant in both Roundtables, as well as a member of the RMC's Health Care Working Committee and Telehealth Subcommittee, obtained a grant to fund this inventory through the Maryland Agriculture Education and Rural Development Assistance Fund (MAERDAF). Administering the survey was sub-contracted to the Maryland Rural Health Association in cooperation with the Rural Maryland Council.

The goal of the survey was to compile an accurate inventory of projects already underway around Maryland so that both those providing and receiving services could better coordinate their efforts, build a foundation for compatible infrastructure, address key issues, reduce redundancy, share findings, and potentially apply for increased funding to support and expand their services. Survey results were also expected to provide insight into difficult policy areas, such as reimbursement, credentialing and licensing, and inform statewide policy and implementation in coordination with the statewide Health Information Exchange (HIE) initiative. The ultimate goal is to use THTM to increase access to quality health care in rural and underserved areas of Maryland. *(A complete report about the RMC's 2008 Rural Roundtable and 2009 Telehealth Roundtable are available on the RMC website at:* **www.rural.state.md.us***)*

Note: For purposes of this survey and report, the Health Resources and Services Administration's definition of telehealth is being used: *Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health and health administration.* Telemedicine is a subset of telehealth and broadly represents the use of electronic communication for the diagnosis, treatment, and transfer of medical clinical data.

Note 2: Maryland has a Health Information Technology State Plan to build a statewide Health Information Exchange (HIE) that would help deliver patient information and data over a secure network supported by the widespread implementation of Electronic Health Records (EHR). Although EHR can help facilitate THTM services, it is not considered THTM per definition.

This is an Interim Report of responses and issues that have been identified to date (September 2010). The RMC intends to convene a Rural Roundtable on December 6, 2010 in Annapolis with stakeholders to discuss these results and findings and consider next steps. The final report, which will be more widely disseminated, may highlight different findings and next steps, depending on subsequent survey results and stakeholder feedback. We expect to release that report in January 2011.

The Maryland Telehealth/Telemedicine Survey
Interim Report, September 2010

With the input from a wide variety of stakeholders across the state, the THTM survey was developed and posted on the Maryland Rural Health Association's Website during FY 2010; however, only a portion of the targeted respondents have completed it. Because the length of the survey was identified as a major barrier to completion, **the MRHA and RMC edited the survey to its most critical 20 questions and re-posted it on the RMC's website at www.rural.state.md.us. It will be available through November 30, 2010. All facilities delivering or receiving telehealth or telemedicine services are strongly encouraged to take the survey.** Those who want to update information they have already provided should email us at: **rmc@mda.state.md.us**.

The Maryland THTM Survey targeted 95 facilities to survey. These facilities include 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 (DHMH). Of this group, 26 facilities representing 48 different THTM sites have responded to date. In addition, 12 of the 95 facilities reported having no involvement in THTM of any kind**.**

Four major conclusions can be drawn from the information and comments received so far:

1) **Reimbursement and Funding is Needed for Expansion:** Virtually every respondent, to date, has indicated a need for (1) reimbursements by state Medicaid and other third-party payors for THTM services; and (2) other funding streams to support the cost of buying, setting up and maintaining THTM equipment and related administrative costs.

   Reimbursement:

   Without question, the need for reimbursement is the top priority of those who have taken the survey to date. Those currently providing clinical services through THTM projects are not being reimbursed for those services. Costs are either being paid for by specific grants or being absorbed by the participating facilities. This model is unsustainable over the long term and makes expansion into poorer, more remote communities and rural hospitals hard to imagine.

   Maryland is one of only 18 states that Medicaid does not reimburse for the provision of telemedicine services. In 2006, 27 states had Medicaid policies regarding the reimbursement of TMTH; today, 32 states have Medicaid reimbursing policies. In 2010, Virginia became the 12th state to mandate private health plans cover THTM. Even without mandates overall, 26 states have private payors reimbursing for TMTH, but Maryland is not one of them.

   Additionally, Medicare has been reimbursing telemedicine services nationally since 1997 in rural Health Professional Shortage Areas. HPSAs are designated by the Health Resources and Services Administration (HRSA) as having shortages of primary medical care, dental or mental health providers and may be geographic (a county or service area), demographic (low income

population) or institutional (comprehensive health center, federally qualified health center or other public facility). Currently 20 of Maryland's 24 counties (or parts of counties) have some type of federally designated primary care HPSA. This number is up from the 10 counties (or parts of counties) in 2006. While many of these counties are considered urban all of Maryland's federally recognized rural counties (i.e., Allegany, Caroline, Dorchester, Garrett, Kent, Somerset, St. Mary's, Talbot, Worcester) have at least one of the categories of a primary care HPSA designation.

In a recent development, DHMH has approved regulations that take effective in September 2010 that allow Medicaid reimbursement for Telemental services delivered in areas DHMH designates as "underserved." The partners of this survey will monitor how those regulations are used and how reimbursement affects service.

Other Funding:

Federal Funding for Telemedicine has expanded in the last few years but Maryland continues to lag behind other states in securing these funds. For instance the USDA-Rural Development Distance Learning and Telemedicine (DLT) Funds has not had a Maryland grantee since 2003 when Sheppard Pratt received funding to facilitate a telemental service which is still sustaining today. The FCC Rural Healthcare Pilot Programs awarded 69 statewide or regional broadband telehealth networks in 42 states, but none in Maryland. Some projects, like the Mid Shore Mental Health Systems, University Maryland School for Medicine, and Johns Hopkins School of Nursing have secured recent federal funds to develop TMTH projects, but these are not part of a coordinated statewide plan. Of those who are providing THTM service, many indicated a desire to expand to other rural parts of the state, but all indicated they need help financing the service, either by obtaining funding for the direct cost of equipment and administration, or by obtaining reimbursement for clinical services.

2) **There is a Lack of State Leadership Surrounding Telehealth Coordination:** While many individual facilities, partnerships and practices are dedicated to implementing and expanding TMTH services in their areas and facilities, there is no clear state leader in charge of coordinating and expanding TMTH in Maryland. Services are not coordinated through any one agency or organization, and multiple state and federal agencies are funding THTM projects. As a result, implementation is moving very slowly, and Maryland continues to miss out on federal funding opportunities because of its lack of coordination. Indeed, because individual facilities and programs have started THTM projects on their own, rather than part of a coordinated statewide effort, even large, reputable medical institutions themselves indicated that they do not have an accurate inventory of THTM projects within their own systems. Merely finding out where THTM is being offered in Maryland – a question the partners undertaking his survey thought would be, if not easy, at least do-able – are now not so sure a complete inventory can be assembled. Without a statewide leader, THTM projects around the state will continue to be implemented on a piecemeal and project-by-project basis by those facilities that can afford to do it, and real

changes in policies or plans that would expand services in rural or underserved areas will not be made.

It should be noted that reports and task forces over the last decade have addressed how to expand and overcome TMTH barriers, but solid leadership, solutions, or large state or federal (in Maryland) dedicated funding for THTM expansion has not emerged. While the partners of this survey aim to help facilitate change to expand THTM, they cannot lead the charge without the clear political will of current providers and the state agencies that support them.

3) **Poor access to high-speed broadband services in rural areas deprives some rural residents access to state-of-the-art medical care** simply because it is impossible to provide THTM services without it. Some large urban institutions have tried to reach these communities but have not been as successful as they could be due to a lack of vendors and broadband service. In addition to all the other economic development barriers that a lack of broadband access creates, it also deprives under-served rural Marylanders of equal access to health care because of where they live. In addition, with so many projects being started in isolation, there is a real risk that the technological infrastructure being developed and implemented in one facility will be incompatible with others, making expansion of one program or even a statewide system difficult, perhaps impossible, to realize. Institutions surveyed indicated they are not clear on how to mobilize their own projects and policies to move the technology forward.

4) **Issues related to licensing and credentialing providers across state lines were also listed as barriers** to providing THTM services. The University of Maryland School of Law, Law and Health Care Program, held a Roundtable on the Legal Impediments to Telemedicine in April 2010. Both the RMC and MRHA attended as observers. The Roundtable took a day-long, in-depth look into the legal questions that are still unresolved involved licensing and credentialing across state lines. The Law School prepared an excellent, highly readable White Paper, clearly laying out the conflicts and questions that remain. The RMC and MRHA will continue to support and communicate with the Law School as they work with stakeholders and practioners to develop recommendations and solutions.

Currently, small, rural hospitals must individually appraise, review and credential all providers they work with, including those from large urban centers who are delivering specialty services by THTM and who have the skills and experience that small hospitals are not always in a position to assess. **In a recent development, highlighted in the Law School White Paper, the Centers for Medicare and Medicaid Services (CMS) proposed new regulations in May 2010 that would allow a hospital receiving THTM services (i.e., often small, rural hospitals) to rely upon the credentialing and privileging decisions of the providing hospital, rather than undertake its own review. Comments on these proposed regulations were due in July 2010. A decision is expected by March 2011.**

DRAFT Recommendations, based on survey results to date:

1) Encourage regulatory or legislative change that will enable providers to receive reimbursement for THTM services through Medicaid and eventually private third party payers. We will also monitor the effects of the new regulations that allow telemental services to be reimbursed.

2) Work with statewide THTM stakeholders to identify a state leader who will work to ensure that THTM projects are well coordinated, employing compatible infrastructure, and obtaining the resources necessary to start-up, become sustainable and expand into underserved rural areas. This includes an effort to secure federal funding that has, so far, bypassed Maryland.

3) Encourage state leaders to provide funding to complete construction of the rural broadband network and secure last mile providers to remote rural clinical sites as soon as possible.

4) Continue to collaborate with and support the University of Maryland School of Law's efforts to educate stakeholders and lawmakers on the importance of addressing legal impediments to telehealth.
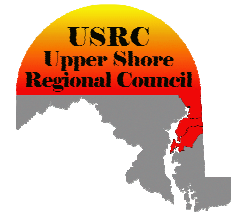
CONCLUSION

The findings and recommendations in the report will be revised after the survey is complete and all stakeholders have had a chance to provide input during the Rural Roundtable in December. All institutions are encouraged to complete the survey at: **www.rural.state.md.us**.

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