

**REPORT OF THE  
JOINT COMMISSION ON HEALTH CARE**

**Options for Increasing the Use of Telemental Health  
in the Commonwealth - Interim Report**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**REPORT DOCUMENT NO. RD 509  
COMMONWEALTH OF VIRGINIA RICHMOND  
November 21, 2017**

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**Vice-Chair**

**The Honorable Rosalyn R. Dance**

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## JOINT COMMISSION ON HEALTH CARE

Senator Charles W. Carrico, Sr., Chair

Senator Rosalyn R. Dance, Vice Chair

December 12, 2017

The Honorable R. Creigh Deeds  
Pocahontas Building, Room No: E503  
Senate of Virginia  
P. O. Box 396  
Richmond, VA 23218

Dear Senator Deeds and Delegate Bell:

As requested, please find attached the Joint Commission on Health Care report: Options for Increasing the Use of Telemental Health in the Commonwealth-Interim Report.

The General Assembly passed Item 30 #1c of House Bill 1500 during the 2017 Legislative Session mandating that the Joint Commission on Health Care (JCHC) study options for increasing the use of telemental health services in the Commonwealth. The budget language specifies that the JCHC shall study options for increasing the use of telemental health services in the Commonwealth and specifically study the issues and recommendations related to telemental health services set forth in the report of the Service System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century ("Joint Subcommittee"). The JCHC shall submit an interim report to the Joint Subcommittee by November 1, 2017 and a final report of its findings to the Joint Subcommittee by November 1, 2018.

Sincerely,

Charles W. Carrico, Sr., Chair

## Preface

A 2017 budget amendment (HB1500 Item 30 #1c) mandated “The Joint Commission on Health Care shall study options for increasing the use of telemental health services in the Commonwealth. The Joint Commission on Health Care shall specifically study the issues and recommendations related to telemental health services set forth in the report of the Service System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century...The Joint Commission on Health Care shall submit an interim report to the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century by November 1, 2017 and a final report of its findings to the Joint Subcommittee by November 1, 2018.”

The Telemental Health Work Group (*The Work Group*) identified six barriers to expanding telemental health in the Commonwealth, offered twenty-nine options, and proposed twelve recommendations based on their potential for high impact and an ability to be achieved within a twelve-month period. The JCHC interim report focuses on a sub-set of the twelve recommendations that are most amenable to action during the 2018 General Assembly session. These recommendations involve support for several activities that work synergistically and include: (1) Project ECHO; (2) updating the Southside Training and Telehealth Academy (STAR) resources; (3) a pilot telemental health network to expand access to behavioral health; (4) a directory of telehealth providers that can be accessed by individuals and used by non-behavioral health services providers; and (5) a request that the JCHC conduct a study to determine the feasibility of central or regional telepsychiatry resources that could serve all the Community Services Boards (CSBs) in the state.

By the date of the JCHC Decision Matrix meeting, in which members vote on the policy options in the staff studies, the Joint Subcommittee to Study Mental Health Services in the 21st Century had not yet formally considered or voted on the recommendations in the report from the Telemental Health Work Group on Policy Development. As such, JCHC members chose to not vote on the JCHC policy options at that time; and instead voted to “take no action.”

Paula Margolis, Ph.D., MPH, Senior Health Policy Analyst at the JCHC is conducting the study. Please contact her if you have any questions or comments.

Joint Commission members and staff would like to thank the individuals who assisted in this study, including The Honorable William Hazel, M.D., Secretary, and Kenneth Flores, Deputy Secretary, from the Virginia Office of the Secretary of Health and Human Resources; Karen Reuban, M.D., and Kathy Wibberly, Ph.D., Director, from the University of Virginia Center for Telehealth; Richard Bonnie, M.D., and John E. Oliver from the University of Virginia Law School Institute of Law, Psychiatry and Public Policy; Kate Marshall, Substance Abuse Services Council, and Janet Lung, Office of Child and Family Services, from the Virginia Department of Behavioral Health and Developmental Services; Carol Pratt, Policy Advisor to the Commissioner, from the Virginia Department of Health; and Jeff Nelson, Senior Policy Analyst, from the Virginia Department of Medical Assistance Services.

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## Executive Summary

A 2017 budget amendment (HB1500 Item 30 #1c) mandated that the Joint Commission on Health Care (JCHC) study options for increasing the use of telemental health in the Commonwealth and to focus on the issues and recommendations made by the Telemental Health Work Group (*The Work Group*) which is a sub-group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century. The JCHC study will span two years and include this interim report and a final report to be submitted by November 2018.

The Work Group identified six barriers to expanding telemental health in the Commonwealth, offered twenty-nine options, and proposed twelve recommendations based on their potential for high impact and an ability to be achieved within a twelve-month period. The JCHC interim report focused on a sub-set of the twelve recommendations that are most amenable to action during the 2018 General Assembly session. Several of the recommendations fit together synergistically to address access issues in Southwestern Virginia and statewide, and if implemented could help address the opioid crisis in the region. These recommendations include: (1) Project ECHO, which provides clinical support and education to health care providers who are not in behavioral health settings; (2) updating the Southside Training and Telehealth Academy (STAR) resources that provide technical and management training needed to operate and administer a telehealth service; (3) establish a pilot telemental health network to expand access to behavioral health involving the Virginia Telehealth and Appalachian Telemental Health Networks. State funds provided for this effort may be used to leverage additional grant funds from the Tobacco Regional Revitalization Commission and the Appalachian Regional Commission to help expand broadband capacity; (4) create a directory of telehealth providers that can be accessed by laypersons and used by non-behavioral health services providers to refer patients in Appalachia and possibly statewide; and (5) request that the JCHC conduct a study to determine the feasibility of central or regional telepsychiatry contracting that to serve all the Community Services Boards (CSBs) in the state.

In total, the Work Group estimates that \$1,100,000 of State General Funds per year for three years would be required to implement the recommendations. The Work Group anticipates that these activities will be sustainable after the three-year funding period. The final JCHC report on this issue will address progress achieved between this interim report and November 2018, as well as other Work Group recommendations.

By the date of the JCHC Decision Matrix meeting, in which members vote on the policy options in the staff studies, the Joint Subcommittee to Study Mental Health Services in the 21st Century had not yet formally considered or voted on the recommendations in the report from the Telemental Health Work Group on Policy Development. As such, JCHC members chose to not vote on the JCHC policy options at that time; and instead voted to “take no action.” These recommendations will be brought to the Joint Subcommittee to Study Mental Health Services in the 21st Century’s full committee in December 2017.

## **Options for Increasing the Use of Telemental Health in the Commonwealth – Interim Report**

### ***Introduction***

A 2017 budget amendment (HB1500 Item 30 #1c) mandated that the Joint Commission on Health Care (JCHC) study options for increasing the use of telemental health services in the Commonwealth, including the recommendations set forth in the report of the Telemental Health Work Group (*The Work Group*) of the Services System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century. The Work Group submitted its findings on October 6, 2016 and issued a subsequent report on ‘next steps’ in the Fall of 2017. The JCHC study will span two years and include this interim report and a final report to be submitted by November 1, 2018.

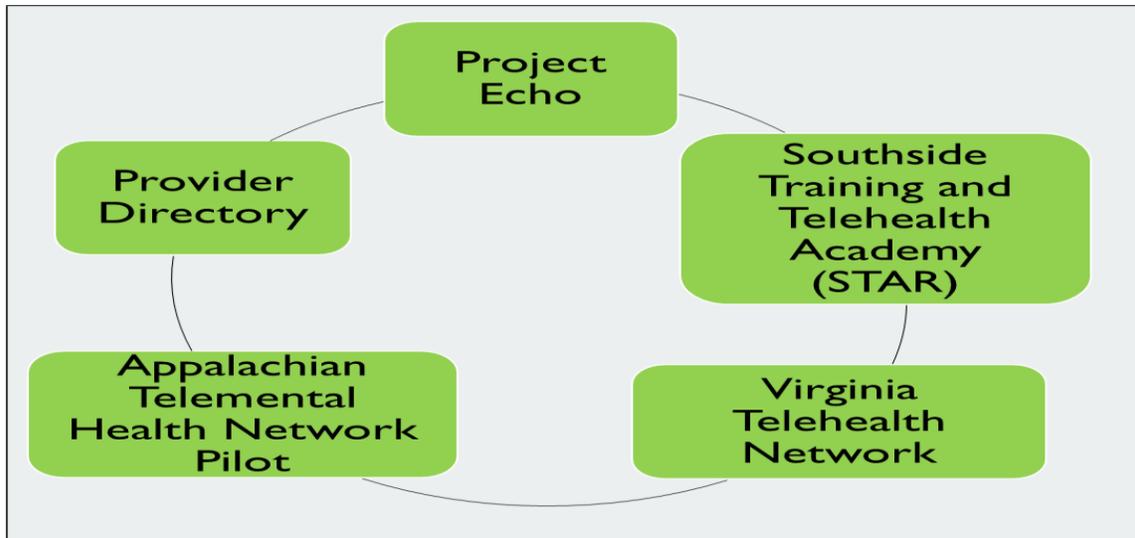
### ***Background***

The Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century formed several work groups to deal with specific aspects of mental health services delivery, including a work group to identify barriers to, and make recommendations for, expanding the use of telemental health in the Commonwealth. The work group identified six categories of barriers to expanding telemental health services including provider, workforce, financial, client/patient, policy, and preventive care barriers. In addition, the work group identified twenty-nine options and twelve recommendations to address the barriers (See Attachment 1).

This interim JCHC report focuses on several of The Work Group recommendations that are either in progress and need new resources, involve budget amendments and/or involve issues that can be addressed in the 2018 General Assembly (GA) session. These recommendations work together to educate providers on how to establish a telehealth practice; educate primary care providers on assessing, managing and referring patients to specialists; expand the number of specialists available to individuals living in mental health professional shortage areas; and streamline psychiatric contracting by the Community Services Boards (CSBs). The activities include Project ECHO, updating the resources for the Southside Training and Telehealth Academy (STAR), support for a pilot to expand access to behavioral health in Southwestern Virginia involving the Virginia Telehealth and Appalachian Telemental Health Networks, developing a directory of telehealth providers that can be accessed by laypersons and used by non-behavioral health providers to refer patients in Appalachia, and possibly statewide, and a request that the JCHC conduct a study to determine the feasibility of central or regional telepsychiatry contracting that could serve all the CSBs in the state.

JCHC policy staff provided an interim presentation on these Work Group recommendations to the JCHC members during a meeting held on August 22, 2017 in Richmond, Virginia. The presentation also provided comprehensive information on federal and state regulations, broadband coverage in Virginia and funding for connectivity, and telemental health activities underway in the Commonwealth. Please see Attachment 2 for a copy of the presentation.

**Figure 1: Inter-related Telemental Health Recommendations**



### **Project ECHO®**

Many primary care providers are not trained to treat patients with behavioral/substance use disorders and may feel uncomfortable managing such patients. As a result, primary care providers may wish to refer patients with complex issues to specialists; however, there is a lack of specialists to whom patients can be referred. Primary care providers need resources to help manage and/or refer patients appropriately. Project ECHO fosters knowledge sharing, collaboration, and building the confidence and capacity of providers to appropriately manage patients in the primary care setting and/or refer them to specialists.

Project ECHO began at the University of New Mexico (UNM) in response to the Hepatitis C epidemic that was occurring within a mostly rural state with many underserved areas. Project ECHO was then expanded to treat substance use, behavioral health, and many chronic health conditions. Project ECHO employs a collaborative practice model using the *spoke and hub* system that links expert specialist teams at an academic ‘hub’ with primary care clinicians in local communities – the ‘spokes’ of the model. Project ECHO sessions allow for a team of specialists to consult on de-identified patient cases via video conferencing with primary care and other providers across the state. Sessions include a didactic section on pre-determined topics (including medication assisted treatment for substance use), and continuing medical education credits are available. Providers can participate over computers and smart phones.

The Virginia Department of Health received a one-year grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a pilot Project ECHO program in Virginia which is co-administered by the Virginia Department of Medical Assistance Services (DMAS). The Project ECHO pilot is scheduled to launch in early 2018 and includes three hubs at the University of Virginia (UVa), Virginia Commonwealth University (VCU) and Virginia Tech/Carilion. Hubs will oversee curriculum development, rotation of specialists and administrative support, and provide other resources. Virginia agency staff received training on Project ECHO at the University of New Mexico in the Summer of 2017. The University of New

Mexico also provides the free software used for Project ECHO and will assist in evaluating the results of the Virginia pilot.

Ongoing funding is needed to maintain and expand the program beyond the one-year pilot period and to add other sites and subject areas. The Work Group estimated that \$300,000 per year, for three years, is required to maintain and expand Project ECHO in the Commonwealth. Funds would be used for office space and administrative costs, payment to hub providers, technology, equipment and connectivity fees. The Work Group recommends that General Funds in the above amount be allocated for Project ECHO. As with all of the programs discussed in this report, Project ECHO is expected to be financially sustainable without General Funds after the initial three years.

### ***Southside Training and Telehealth Academy (STAR)***

STAR is a partnership of the University of Virginia Center for Telehealth and the New College Institute located in Martinsville, Virginia. The New College Institute (NCI) is a state-funded educational entity that provides access to bachelor's degree completion programs, master's degrees, teacher endorsement programs, teacher recertification courses, and other resources through partnerships with colleges and universities. The STAR Telehealth programs are low cost and include training for providers, technology professionals, and telehealth presenters who help facilitate telehealth visits, as well as training on protecting personal health information (see Figure 2). The STAR platform, website and content were created in 2012 and are outdated and need to be refreshed. The Work Group estimates that it would take \$100,000 to update STAR and recommends that General Funds be allocated for this purpose.

**Figure 2: STAR Training Topics**

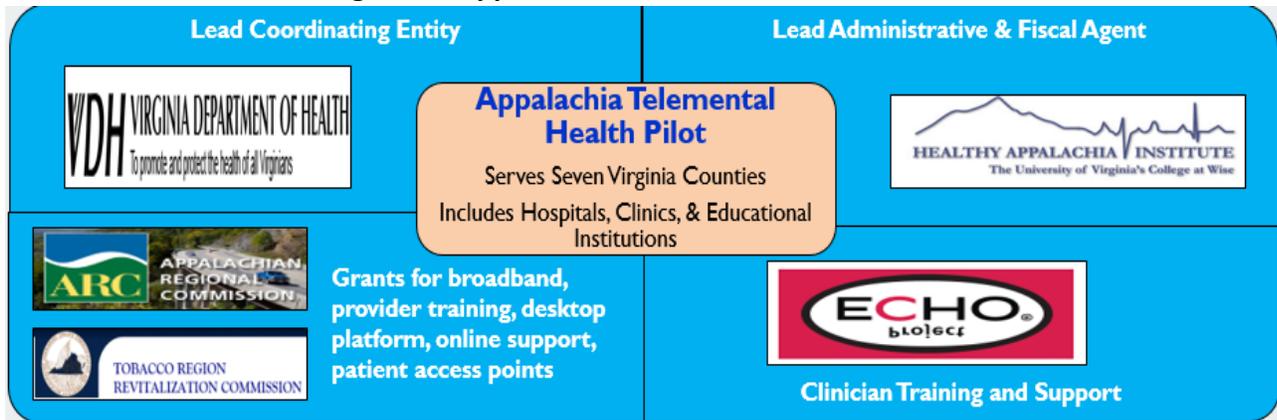
- |  |  |
|--|--|
| <ul style="list-style-type: none"><li>• <b>Board Certified Telemental Health Provider training for mental health professionals includes:</b><ul style="list-style-type: none"><li>• Crisis Management</li><li>• Settings and Care Coordination</li><li>• Direct-to-Consumer legal and ethical requirements</li><li>• Orienting Clients</li><li>• Choosing and Using Technology</li></ul></li><li>• <b>Certified Telemedicine Clinical Presenter training</b><ul style="list-style-type: none"><li>• Telemedicine Essentials</li><li>• Live Video/Store, Foreword, Remote Monitoring</li><li>• Consultation Protocols</li><li>• Video Conferencing Etiquette &amp; Record Keeping</li></ul></li></ul> | <ul style="list-style-type: none"><li>• <b>Certified Telehealth Coordinator/Technical Professional</b><ul style="list-style-type: none"><li>• Technology Used &amp; Live Interaction Visit</li><li>• The Telehealth Coordinator and Team</li><li>• Clinical Basics and Working with the Presenter</li><li>• Remote Patient Monitoring</li></ul></li><li>• <b>HIPPA training</b><ul style="list-style-type: none"><li>• Purpose of HIPAA &amp; HIPAA Standards</li><li>• Identifying Breach Scenarios</li><li>• How to be HIPAA Compliant</li><li>• Business Associates Agreements</li><li>• Penalties and Fines Related to Breaches</li><li>• Role of HIPAA Audits</li></ul></li></ul> |
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(Source: <http://www.startelehealth.org/certificates-and-credentials>)

### Appalachia Telehealth Network Pilot

The Appalachia Telehealth Network Pilot would involve several organizations including: Virginia Department of Health (VDH) (which would be the lead coordinating agency and has already begun work on Project ECHO), Appalachian Regional Commission (ARC), the Tobacco Region Revitalization Commission (TRRC), and the Healthy Appalachia Institute at the University of Virginia in Wise, Virginia which would administer the program and serve as the fiscal agent (see Figure 3).

**Figure 3: Appalachia Telemental Health Pilot**



The goals of the recommended pilot are to expand and enhance access to quality affordable mental health services in Appalachia, allowing for efficient, early and accurate diagnoses; and to reduce travel time and costs. The pilot would create an online database of network providers to allow for shared feedback on technology, equipment, trainings, and certifications; and to provide a support community for providers across Appalachia. The pilot would also establish an on-line referral network (discussed below) that will allow providers to post information about specialty and state licenses, enable patients to identify providers with open appointments, and display patient ratings of providers and patient satisfaction.

The Appalachian Telemental Health Network would be composed of a regional broadband health network using an interoperable, standards-based system to allow for multiple vendor platforms. The pilot will assess broadband infrastructure throughout the region to close gaps; develop partnerships with regional providers, clinics, hospitals, public health institutes and institutes of higher education; and explore innovation through the development and testing of new technologies. As administrative lead, the Healthy Appalachian Institute would apply for funding from the ARC and TRRC.



### ***Other Recommendations***

In addition to the above recommendations, the Work Group recommended that the JCHC conduct a study on the feasibility of statewide contracting for tele-psychiatric services by the Community Services Boards. Currently, the CSBs are each responsible for individual contracting, which the Work Group believes may be inefficient, particularly in light of the fact that CSBs serve urban, rural, and suburban areas with some CSBs requiring several full-time equivalent psychiatric staff, while others may only require a few hours per month. They envision that the Virginia Department of Behavioral Health and Developmental Services (DBHDS) function as a central contracting agent for all CSBs statewide.

### ***Conclusion***

The Work Group made twelve recommendations to expand telemental health in the Commonwealth, and a budget amendment (HB1500 Item 30 #1c) mandated that the JCHC report on the recommendations. Several of the recommendations fit together synergistically to address access issues in Southwestern Virginia and statewide, and if implemented could help address the opioid crisis in the region. Activities include provider training and support – both clinical support and technical support; training in how to administer a telemental health program, training for telehealth office support staff, establishing an on-line provider directory, software and hardware, provider capacity evaluation, and evaluation of the programs put in place. In total, the Work Group estimates that \$1,100,000 of State General Funds per year for three years would be required to implement the recommendations. State General Funds could be leveraged as a match for ARC and TRRC grants. The final JCHC report on this issue will address progress achieved between this interim report and November 2018, as well as other Work Group recommendations.

## Attachment 1

### Report of the Telemental Health Work Group on Policy Development

#### INTRODUCTION

The Joint Subcommittee to Study Mental Health Services in the Commonwealth in the Twenty-First Century was established through Senate Joint Resolution No. 47 in 2014. The Advisory Panel to the Joint Subcommittee's Work Group on Mental Health Crisis Response and Emergency Services (Work Group #3) identified increased availability of telemental health services in the emergency setting as a high priority. An Advisory Panel work group on telemental health was then formed to develop specific findings and recommendations. Professor Richard Bonnie, advisor to the Joint Subcommittee, asked Katharine H. Wibberly, Ph.D., Director of the Mid-Atlantic Telehealth Resource Center, to chair the telemental health work group, and, as discussed below, gave the group a broad mandate in its review of telemental health services.

Telemental health is the use of electronic information and telecommunications technologies to support behavioral health services at a distance. This includes clinical care, patient and professional health-related education, public health and administration. A variety of modalities can be used to deliver these services, including live interactive videoconferencing, remote monitoring and mobile applications. Providers of telemental health include, but are not limited to psychiatrists, psychologists, social workers, psychiatric nurse practitioners, and licensed professional counselors.

Significant challenges impacting access to and provision of mental health services exist in the Commonwealth of Virginia. Resources available to local and regional community services boards and behavioral health authorities have not kept pace with the increasing number of persons in need of services. This is particularly true in rural and other underserved communities. Multiple reviews of the telemental health literature on its efficacy for diagnosis and assessment across a variety of populations (adult, child, geriatric) and for a variety of disorders and settings have largely shown that it is comparable to in-person care. Telehealth-enabled new models of care (e.g., remote monitoring/hovering, inter-professional collaborative care teams, mobile health) have also demonstrated very positive outcomes. Telemental health is therefore not only viable, but an essential tool for bridging the existing care gap. Despite its demonstrated utility (described in more detail in the presentation made by Anita Clayton, M.D., and Larry Merkel, M.D, Ph.D., at the August 22, 2016 meeting of Work Group #3, [available on the Division of Legislative Services website and linked here]), telemental health has not been widely adopted within the Commonwealth.

The telemental health work group on policy development was given the following task:

***to develop a blueprint for policy proposals designed to remove impediments to greater use of telemental health services.***

More specifically, the work group was asked to provide definition to the problem(s) that need to be addressed and to set forth a menu of policy initiatives or options for addressing the problem(s).

The work group is aware that in order to fully treat some patients, a provider may need to have the ability to prescribe, and that there have been some recent challenges with language in the Code of Virginia pertaining to the requirements of the Drug Control Act and whether a relationship entirely built via telehealth would be considered a valid means for establishing the type of relationship needed to prescribe controlled substances. Adding to the complexity is the federal Ryan Haight Act. The Act provides a definition for the practice of telemedicine and dictates very specific scenarios where the practice of telemedicine would be considered a valid means for the prescribing of controlled substances. Under the Act, the prescribing of controlled substances via telemedicine is allowed in the following scenarios:

- A patient is being treated and physically located in a hospital or clinic registered to distribute under the Controlled Substance Act
- A patient is being treated and in the physical presence of a practitioner registered to distribute under the Controlled Substance Act
- The practitioner is an employee or contractor of the Indian Health Service (IHS) or working for an Indian tribe or tribal organization under contract or compact with IHS
- The practitioner has obtained a special registration from the US Attorney General
- In an emergency situation (21 USC 802(54).)

Although challenges related to prescribing of controlled substances, including psychotropic medications via telemental health continue to exist, headway is being made and the deliberations and recommendations that follow were made under the assumption that impediments to prescribing will be soon resolved.

The following policy framework has been developed by the workgroup and brings definition to six problems. Within each identified problem is a set of policy initiatives or options for addressing the problem, followed by a subset of recommendations for consideration for the 2017 General Assembly Session.

## POLICY FRAMEWORK

<b>Problem 1:</b>	<b>Provider Barriers:</b> Providers are hesitant to use telemental health technologies to facilitate the delivery of care. This hesitancy is a result of several factors: 1) discomfort with the technology; 2) skepticism and uncertainty about the impact of technology on establishing rapport and building relationships with patients/clients; 3) concerns about clinical workflows (protocols, processes, and procedures); and 4) lack of clarity regarding policies (liability/malpractice, privacy and security).
<b>Policy Initiatives/Options</b>	
<b>1</b>	Provide incentives for and/or require clinical mental/behavioral health training programs to offer coursework on telemental health.
<b>2</b>	Provide incentives for and/or require licensed clinical mental/behavioral health providers to obtain continuing education credit in telemental health.
<b>3</b>	Provide incentives for and/or require practicum/internship/residency programs for clinical mental/behavioral health providers to include a telemental health rotation.
<b>4</b>	Provide policy clarification and guidance regarding liability/malpractice; privacy and security requirements, standards of care, and standards for technology and interoperability.
<b>5</b>	Develop a state funded or supported telemental health network that connects public and private providers and facilities and facilitates the sharing of electronic health records. Telemental health networks have enormous potential to provide a wide range of mental health services, provider education, and administrative functions. Several states have developed very successful telemental health networks, including Arizona, South Carolina, North Carolina and Montana. The usefulness of telecommunications technology to enhance a mental health care system is in direct relationship to the extent that it is fully integrated with existing systems of care and coupled with a sustainable business model. This requires an organizational infrastructure that can provide leadership, engage a broad spectrum of stakeholders, deliver training, and assure timely technical assistance.

<b>Problem 2:</b>	<b>Workforce Barriers:</b> Rural and underserved communities often suffer from limited access to mental health services due to difficulties recruiting and retaining mental health specialists. This shortage/maldistribution of the mental health workforce often places non-mental health providers in the position of serving patients with severe mental health problems with little or no specialty support.
<b>Policy Initiatives/Options</b>	
<b>1</b>	Establish loan repayment or scholarship programs for mental/behavioral health providers who provide services to rural and other to-be-defined underserved populations via telemental health
<b>2</b>	Establish statewide Project ECHO (Extension for Community Healthcare Outcomes) clinics focused on mental/behavioral health issues such as pain management, behavioral health disorders, substance use disorders (including the use and abuse of opioids) and other addictions. Project ECHO is a collaborative model of medical education and care management. The ECHO model™ does not actually provide care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. It does this by

	engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub.
<b>3</b>	Establish clinical fellowships in telemental health at academic medical and other mental health/behavioral health professions training programs for the purpose of meeting the identified needs of the public mental health system in the Commonwealth.
<b>4</b>	Establish less restrictive policies that would facilitate telemental health practice across state lines. Examples include the adoption of interstate compacts, establishment of special telemental health licenses, and establishment of expedited licensing processes for telemental health providers.
<b>5</b>	Establish and manage a directory of Virginia-licensed telemental health providers that can serve as a referral network for those seeking services either for themselves or for their patients/clients. This could be in the form of an online searchable database of providers who have been trained to deliver telemental health services.
<b>6</b>	Establish a sub-field in emergency telepsychiatry and provide incentives for participation.

<b>Problem 3:</b>	<b>Financial Barriers:</b> Concerns remain about the sustainability of telemental health services. These include barriers related to reimbursement by both public and private payers (e.g., limitations on the scope of reimbursable services, fee schedules that may not adequately cover costs) and the lack of a mechanism for delivering care to those who are uninsured or underinsured.
<b>Policy Initiatives/Options</b>	
<b>1</b>	Provide enhanced reimbursement for providers who provide telemental health services to rural and other underserved populations.
<b>2</b>	Work with payers to identify funds to provide mental health/behavioral health providers with reduced rates or fee waivers for telemental health certification training and/or reduced rates or fee waivers for license renewals in exchange for banking hours of “free” services to the uninsured/underinsured.
<b>3</b>	Conduct a cost-benefit analysis to examine whether hiring clinicians to provide telemental health services would ultimately reduce the financial burden on emergency services, corrections, hospitals and state psychiatric facilities.
<b>4</b>	Identify and leverage existing resources through public-private partnerships that could be used to train and compensate a pool of clinicians who would be available to serve uninsured/underinsured populations (e.g., job sharing across municipalities, partnerships with hospitals/health systems, payers and foundations, pay as you go contracts) and identify an interoperable portal/platform and process that would enable providers to join the pool.
<b>5</b>	Explore coverage and market reforms to increase available insurance coverage/benefits for telemental health services.
<b>6</b>	Expand the list of originating sites eligible to receive Medicaid coverage for telemental health services to include both schools and homes.
<b>7</b>	Provide incentives for case management services to mitigate the financial burden of “no-shows” on clinicians and leverage mobile health applications to assist with case management (e.g., secure text messaging, mobile apps, remote monitoring/hovering)

<b>Problem 4:</b>	<b>Patient/Client Barriers:</b> Patients/clients may have difficulties accessing telemental health services for a variety of reasons. These include: 1) lack of access to high speed Internet services; 2) lack of access to technology or discomfort with using technology and 3) concerns about stigma associated with seeking treatment for a mental illness.
<b>Policy Initiatives/Options</b>	
	1 Provide incentives/leverage existing incentives (e.g., financial models) for integrating telemental health with primary care services.
	2 Leverage existing Commonwealth broadband efforts and FCC/USAC Program efforts (Rural Health Care, High Cost, Lifeline, and Schools and Libraries Programs) to increase access to broadband and cellular infrastructure in rural and underserved areas.
	3 Develop training programs and establish implementation processes that take into consideration cultural perceptions, stigmas and fear/discomfort with technology.
	4 Develop cost-effective case management models (e.g., peer support, lay health workers/promoters, community paramedics, remote patient monitoring/hovering) to support patients/clients with technology, accessing telemental health, and help people to remain stable.

<b>Problem 5:</b>	<b>Policy Barriers:</b> In order to facilitate the expansion of telemental health, laws and regulations must be updated to ensure that they adequately accommodate new technology-enabled models of care.
<b>Policy Initiatives/Options</b>	
	1 Ensure that a solution is developed to address challenges with prescribing all schedules of psychotropic medications via telemental health as it relates to the establishment of a doctor-patient relationship, the Drug Control Act, and the Ryan Haight Act.
	2 Develop a plan to address continued challenges with access to/sharing of electronic medical records.
	3 Study the current mental/behavioral health workforce and make recommendations for how to better engage and leverage the full continuum of the mental/behavioral health workforce in Virginia (e.g., LCSWs, LPCs, Psych NPs, Psychologists, Psychiatrists), ensuring that they are practicing to the full extent of their education, training and license.
	4 Establish standards of care for out of state providers offering telemental health services in Virginia.
	5 Develop mechanisms (processes and procedures) to ensure that patients have access to recommended formulary and to ensure that medication reconciliation and continuity is facilitated during care transitions.

<b>Problem 6:</b>	<b>Preventive Care Barriers:</b> Prevention of mental disorders and promotion of mental health will reduce the burden associated with mental disorders. However, there is a lack of resources, and lack of awareness of programs and initiatives focused on preventing mental health issues and crises.
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**Policy Initiatives/Options**

- 1** Establish reimbursement and payment models that enable the use of a broad range of mental/behavioral health professionals (psychiatrists, psychologists, LCSWs, and other therapists) to deliver preventive care to a variety of settings (schools, primary care, home, workplace/EAPs, nursing homes, assisted living facilities).
- 2** The Offices of the Secretary of Health and Human Resources and Public Safety develop a plan to raise awareness, educate, identify barriers and facilitate the better use of telemental health services throughout the criminal justice system, particularly with access to telemental health prevention, assessment, and treatment services in regional jails.
- 3** Raise awareness about telemental health and prevention services through direct outreach into the community (e.g., clubhouses, peer run groups).

## RECOMMENDATIONS

Of the twenty-nine policy initiatives/options identified in the Policy Framework, the Telemental Health Work Group on Policy Development would like to put forward the following twelve for immediate consideration. The following policy initiatives/options have potential for high impact and could be reasonably achieved in a 12 month period.

To address **Provider Barriers**, it is recommended that:

1. The Office of the Secretary of Health and Human Resources provide policy clarification and guidance regarding liability/malpractice; privacy and security requirements, standards of care, and standards for technology and interoperability. The Georgia Public Policy Foundation has developed “The Guide to the Issues” (<http://www.georgiapolicy.org/additional-links/guidetotheissues/>) on a variety of topic areas and these guides could potentially serve as a model.
2. The Commonwealth leverage Appalachian Regional Commission and Virginia Tobacco Region Revitalization Commission funding to implement a pilot telemental health network to address the mental health needs of the counties within their respective footprints. The pilot telemental health network should prioritize addressing the opioid epidemic that is having devastating human costs and hindering economic and workforce development in these communities. The pilot telemental health network should engage and leverage the full continuum of the mental/behavioral health workforce and also include Project ECHO clinics to provide front-line clinicians with the knowledge and support they need to manage patients with opioid addictions.

To address **Workforce Barriers**, it is recommended that:

3. The Commonwealth appropriate \$300,000 per year to establish statewide Project ECHO (Extension for Community Healthcare Outcomes) clinics focused on mental/behavioral health issues such as pain management, behavioral health disorders, opioids, substance abuse, and other addictions. Project ECHO is a collaborative model of medical education and care management. The ECHO model™ does not actually provide care to patients. Instead, it dramatically increases access to specialty treatment in rural and underserved areas by providing front-line clinicians with the knowledge and support they need to manage patients with complex conditions. It does this by engaging clinicians in a continuous learning system and partnering them with specialist mentors at an academic medical center or hub.
4. Clinical fellowships in telemental health at academic medical and other mental health/behavioral health professions training programs be established for the purpose of meeting the identified needs of the public mental health system in the Commonwealth. The University of Virginia Center for Telehealth has an existing model for training the next generation of clinicians in telehealth that could serve as a model for

other health professions training programs.

5. The Commonwealth appropriate \$50,000 per year to the Virginia Telehealth Network to establish and manage a referral network of Virginia-licensed telemental health providers.

To address **Financial Barriers**, it is recommended that:

6. The Joint Commission on Healthcare study the costs/benefits of different models for providing telemental health services and their impact on reducing the financial burden on emergency services, corrections, hospitals and state psychiatric facilities. Models could include providing outpatient telemental health services in the community to patients with sub-acute needs, providing consulting/collaborating services in the ED to reduce psychiatric boarding, and assessing whether having the Virginia Department of Behavioral Health and Developmental Services hire providers who can dedicate themselves to providing telemental health services statewide would be more cost-effective than contracting with providers to deliver these services.
7. The Office of the Secretary of Health and Human Resources identify and leverage existing resources through public-private partnerships (payers, foundations, etc.) that could be used to train and compensate a pool of clinicians who would be available to serve uninsured/underinsured populations (e.g., job sharing across municipalities, partnerships with hospitals/health systems, payers and foundations, pay as you go contracts) and identify an interoperable portal/platform and process that would enable providers to join the pool.
8. The Virginia Department of Medical Assistance Services expand its list of eligible originating sites for telemental health services to include both schools and homes.

To address **Patient/Client Barriers**, it is recommended that:

9. The Offices of the Secretary of Health and Human Resources and the Secretary of Technology identify ways to leverage existing Commonwealth broadband efforts and FCC/Universal Services Administrative Company (USAC) Program efforts (Rural Health Care, High Cost, Lifeline, and Schools and Libraries Programs) to increase access to broadband and cellular infrastructure in rural and underserved areas.

To address **Policy Barriers**, it is recommended that:

10. The Commonwealth makes every effort to ensure that a solution is developed to address challenges with prescribing all schedules of psychotropic medications via telemental health as it relates to the establishment of a doctor-patient relationship, the Drug Control Act, and the Ryan Haight Act. Efforts to address this are currently being

led by Virginia State Senator Dunnavant.

- 11.** The Joint Commission on Healthcare study the current mental/behavioral health workforce and make recommendations for how to better engage and leverage the full continuum of the mental/behavioral health workforce in Virginia (e.g., LCSWs, LPCs, Psych NPs, Psychologists, Psychiatrists), ensuring that they are practicing to the full extent of their education, training and license.

To address **Preventive Care Barriers**, it is recommended that:

- 12.** The Offices of the Secretary of Health and Human Resources and Public Safety develop a plan to raise awareness, educate, identify barriers and facilitate the better use of telemental health services throughout the criminal justice system, particularly with access to telemental health prevention, assessment, and treatment services in regional jails.

**OPTIONS FOR INCREASING THE USE OF TELEMENTAL HEALTH SERVICES IN THE COMMONWEALTH**

**Interim Report**

**Joint Commission on Health Care  
August 22, 2017 Meeting**



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**STUDY MANDATE – HB1500 ITEM 30 #1C**

“The Joint Commission on Health Care (JCHC) shall study options for increasing the use of telemental health services in the Commonwealth....

Specifically the issues and recommendations set forth in the report of the Telemental Health Work Group of the Services System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century...

The Joint Commission on Health Care shall submit an interim report to the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21<sup>st</sup> Century by November 1, 2017 and a final report of its findings to the Joint Subcommittee by November 1, 2018.”



The telemental health sub-work group offered twelve recommendations in their final report



Today's presentation will focus on a sub-set of the recommendations that may be actionable in the 2018 General Assembly Session



## PRESENTATION OVERVIEW

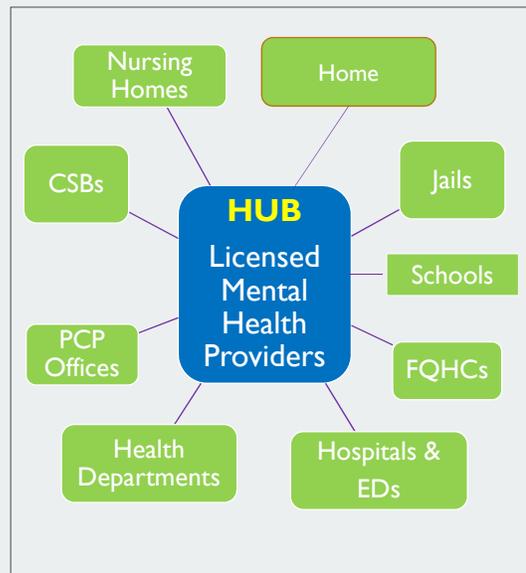
1. Telehealth terms
2. Federal regulations
3. Virginia regulations, policies and activities
4. Virginia broadband communications infrastructure and Federal programs
5. Telemental Health Sub-Committee Report
  - I. Report Framework
  - II. Report Recommendations
6. Policy Options



## TELEHEALTH TERMS

- **Telemedicine** – the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance
- **Originating or “spoke” site** – where the patient is located at the time the service is being furnished
- **Distant or “hub” site** - where the physician or other provider who is delivering the service is located
- **Telepresenters** – Staff at the spoke site who facilitate the delivery of the service
- **Asynchronous, or ‘store and forward’, technology** - transfer of data from one site to another through the use of a camera or similar device that records an image that is sent via telecommunication to another site for consultation
- **Reimbursement** – Can include a provider fee (paid to provider at the hub site) and a facility fee (paid to the spoke site) and in some cases may include reimbursement for transmission charges and equipment costs

## SPOKE AND HUB MODEL



5

## FEDERAL REGULATIONS



6

## THE RYAN HAIGHT ONLINE PHARMACY CONSUMER PROTECTION ACT OF 2008



- The Ryan Haight Act requires that no controlled substance may be delivered, distributed or dispensed by means of the Internet without a valid prescription obtained by a practitioner (or their covering practitioner) who has conducted at least one in-person medical evaluation of the patient
- The Act provides for seven (7) exceptions to the in-person evaluation requirement

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## RYAN HAIGHT ACT, CONT'D

1. The patient is treated by, and physically located in, a hospital or clinic which has a **valid DEA registration**
2. The patient is being treated in the presence of another **DEA registered practitioner**
3. The practitioner is an employee or contractor of the **Indian Health Service or Tribal authority**
4. During a Department of **Veterans Affairs medical emergency**
5. The DEA Administrator and Secretary of Health and Human Services have **jointly determined** to be acceptable

6. The practitioner has obtained a **special registration** from the DEA under section 311(h) of the Act (21 U.S.C. 831(h))

7. During a declared **public health emergency**

On August 10, 2017 President Trump **declared the opioid crisis a public health emergency**

- Secretary Price could allow '**standing orders**' for naloxone without a prescription and could **waive the special certification requirement** for doctors who want to administer methadone or buprenorphine
- Once the prescribing practitioner has conducted an in-person medical evaluation, the Ryan Haight Act **does not set an expiration period or require subsequent re-examinations**

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## RYAN HAIGHT ACT, CONT'D



- Despite the seven exceptions, **barriers continue to exist** for patients to receive care from legitimate telemedicine providers who are in full compliance with state law
- The seven exceptions function well for institutional telemedicine arrangements, but may not work:
  - When the patient is being seen at a non-DEA registered facility or without a DEA registered practitioner on site
  - In sites such as school-based health clinics, work site clinics, or private practice offices of an LPC and LCSW
  - When the patient is **in their home** at the time of the telemedicine consult
- In 2016, DEA announced plans to issue a new rule expanding the DEA registration process
  - The most recent notice of rulemaking stated the proposed rule was expected to be published in January 2017
  - The proposed rule has not yet been released, but is anticipated to be published this year



## MEDICARE TELEHEALTH POLICY

Social Security Act, Sec. 1834(m) [42 C.F.R. § 410.78]

- The Medicare beneficiary must be located in a **Health Professional Shortage Area** as determined by the Health Resources and Services Administration

### **Allowed Originating (Spoke) Sites include:**

- Entities that participate as a Next Generation Accountable Care Organization or in a Federally approved telemedicine demonstration project
- Physician and practitioner offices
- Hospitals, including Critical Access Hospitals (CAH)
- Rural Health Clinics
- Federally Qualified Health Centers (FQHCs)
- Hospital-based or CAH-based renal dialysis centers and their satellites

### **Allowed Distant (Hub) Site Practitioners include:**

- Physicians
- Nurse Practitioners
- Physician Assistants
- Nurse-midwives
- Clinical nurse specialists
- Certified nurse anesthetists
- Clinical psychologists/social workers
- Registered dietitians and nutrition professionals





## MEDICARE TELEHEALTH POLICY, CONT'D.

- Services must be delivered using a system that permits **real-time communication between sites**
  - Historically, asynchronous “store and forward” has only been permitted in federal telemedicine demonstration programs in **Alaska & Hawaii**
  - In March 2015, the Centers for Medicare and Medicaid Services (CMS) approved the first non-face-to-face procedure codes for certain clinical staff to perform extensive assessment for Medicare beneficiaries with **multiple chronic conditions** who meet specific criteria specified by CMS
  - These services are not restricted by geographic location or prohibitions on the use of asynchronous technology in most cases
- **Pending federal legislation:**
  - **HR 3360** would allow urban critical access and sole community hospitals, home sites and counties with fewer than 25,000 people to be eligible for Medicare payments for telehealth
  - **HR 2123 and S 925** would allow health care professionals employed or contracted with the Department of Veterans Affairs to **treat VA patients** in any state using telemedicine **regardless of where they are located**
  - **HR 3545** Overdose Prevention and Patient Safety Act would reform 42 CFR Part 2, which governs substance use disorder data sharing to align disclosure rules with the Health Insurance Portability and Accountability Act (HIPAA). The legislation would **prohibit valid disclosures from being used to initiate or substantiate a criminal charge or investigation.**



## PENDING FEDERAL REGULATION, CONT'D.

### **S. 1377 - RURAL Act:**

would allow non-rural health care providers serving rural areas to qualify for support from the Federal Communication Commission's (FCC) Healthcare Connect Fund.

### **HR 2550 - Medicare Parity Act**

would ease geographic and other limitations on the use of telehealth in the Medicare program through a phase-in approach in which the geographic location and facilities a telehealth service can be rendered are gradually expanded. Additionally, HR 2550 would expand the use of store and forward to deliver services, and allow additional practitioners and services to be eligible for telehealth reimbursement.

### **HR 2291 - HEART Act**

was introduced in early May, and proposes to amend title XVIII of the Social Security Act to expand the coverage of telehealth services under the Medicare program, to provide coverage for home-based monitoring for congestive heart failure and chronic obstructive pulmonary disease.

### **S. 1016/HR 2556 - CONNECT Act**

allows for the waiver or elimination of the telehealth restrictions in Medicare under certain conditions effective Jan. 1, 2018. The CONNECT Act would also allow for the coverage of remote patient monitoring (RPM) services when delivered by an eligible provider to an applicable patient.

### **S 870 - CHRONIC Act**

proposes to expand coverage for telehealth services within several key Medicare programs, including: Medicare Advantage plans, the End Stage Renal Disease (ESRD) Program, applicable Accountable Care Organizations (ACOs), and for individuals with stroke.



## FEDERAL MEDICAID TELEHEALTH POLICY



- The general Medicaid requirements of comparability, statewideness and freedom of choice do **not** apply with regard to telemedicine services
- States are not required to submit a (separate) State plan amendment (SPA) for coverage or reimbursement of telemedicine services if they decide to reimburse for telemedicine services the same way/amount that they pay for in-person services
- States must submit a separate reimbursement SPA if they want to provide reimbursement for telemedicine services or components of telemedicine differently than is currently being reimbursed for in-person services

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## VIRGINIA REGULATIONS, POLICIES AND ACTIVITIES



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**COVERAGE FOR TELEHEALTH SERVICES ENACTED  
JANUARY 2011- CODE OF VIRGINIA §38.2-3418.16**



“...each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services **shall provide coverage for the cost of such health care services provided through telemedicine services**, as provided in this section.”

“This section shall not apply...to policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans.”

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**CODE OF VIRGINIA §54.1-3303 PRESCRIPTIONS TO BE ISSUED AND DRUGS TO BE DISPENSED FOR  
MEDICAL OR THERAPEUTIC PURPOSES ONLY**

For the purpose of prescribing a Schedule VI controlled substance via telemedicine... **a prescriber may establish a bona fide provider-patient relationship by face-to-face exam through interactive, 2-way, real-time communications or store-and-forward technologies when all conditions below are met:**

(a) the patient has provided a **medical history** that is available for review by the prescriber

(b) the prescriber obtains an **updated medical history** at the time of prescribing

(c) the prescriber **makes a diagnosis** at the time of prescribing

(d) the prescriber conforms to the **standard of care** expected of in-person care appropriate to the patient's age and presenting condition, including when the standard of care requires use of diagnostic testing and performance of a physical exam, **which may be carried out through the use of peripheral devices...**

(e) the prescriber is actively **licensed in the Commonwealth** and authorized to prescribe

(f) if the patient is a member or enrollee of a health plan/carrier, the prescriber has been **credentialed** by the health plan/carrier as a participating provider and the diagnosing and prescribing meets the qualifications for reimbursement by the health plan/carrier pursuant to § 38.2-3418.16 and

(g) upon request, the prescriber **provides patient records** in a timely manner in accordance with the provisions of § 32.1-127.1.03 and all other state and federal laws and regulations. **Nothing in this paragraph shall permit a prescriber to establish a bona fide practitioner-patient relationship for the purpose of prescribing a Schedule VI controlled substance when the standard of care dictates that an in-person physical examination is necessary for diagnosis**

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## VIRGINIA BOARDS OF MEDICINE AND NURSING GUIDANCE



- The Virginia Boards of Medicine and Nursing revised their guidances related to telemedicine practiced by physicians and nurse practitioners in 2017; guidances include:
  - Providers must establish a practitioner-patient relationship and adhere to regulations regarding prescriptions to be issued as defined in *Virginia Code* §54.1-3303 and §54.1-3408-01
  - The practice of medicine occurs **where the patient is located**; therefore, the practitioner must be licensed, or under the jurisdiction of, the regulatory board of the state where both the patient and practitioner are located
  - Telemedicine **does not include** an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaires

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## VIRGINIA MEDICAID TELEHEALTH POLICY

- Telehealth is available to individuals enrolled in:
  - Commonwealth Coordinated Care (CCC)
  - CCC Plus
  - Governor's Access Plan
  - Medallion 4.0 MCOs
  - Fee-for-Service providers
- Allowed store and forward services include:
  - Radiology
  - Diabetic retinopathy screening
  - Tele-dermatology and others
- No reimbursement for email, phone or FAX



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## VIRGINIA MEDICAID TELEHEALTH POLICY

- All providers must be enrolled with the Department of Medical Assistance Services (DMAS)
- Out-of-state physicians must be licensed to practice in Virginia and enrolled in the Medicaid program in the state in which they reside

### Allowed Hub Providers:

- Physicians
- Nurse practitioners, including psychiatric nurse practitioners, clinical nurse specialists, including psychiatric clinical nurse specialists, and nurse midwives
- Clinical psychologists, clinical social workers, professional counselors, marriage and family therapists/counselors licensed by the Virginia Board of Counseling
- Local Education Agencies (speech therapy only), school psychologists licensed by the Virginia Department of Health Profession's Board of Psychology, and substance abuse treatment practitioners

### Allowed Spoke Sites:

- Rural Health Clinics
- FQHCs
- Hospitals (general, mental health, long stay & rehab)
- Nursing Facilities
- Health Department Clinics
- Renal Units (dialysis centers)
- Community Services Boards
- Residential Treatment Ctrs

DMAS is in the process of updating the allowed originating and remote sites, clarifying the ability of FQHCs to bill as a hub site and examining changing their payment model from delineating which telehealth services **are** eligible for payment to delineating which services **are not** eligible for services (would be more inclusive)

## FEDERAL AND VIRGINIA BROADBAND COMMUNICATIONS INFRASTRUCTURE AND ACTIVITIES



FEDERAL COMMUNICATIONS COMMISSION 2016 BROADBAND PROGRESS REPORT\*



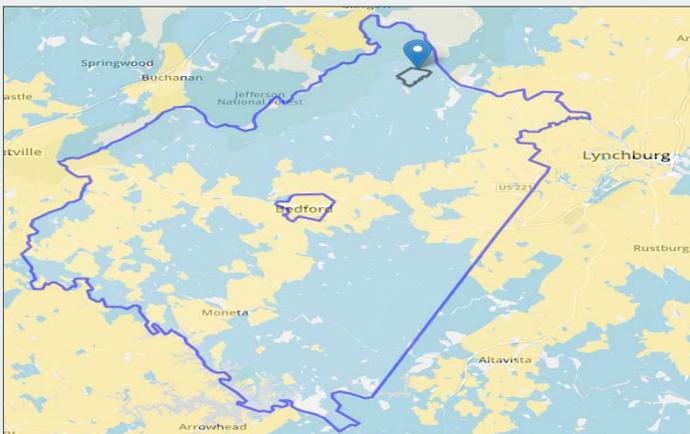
- **Fixed broadband** includes terrestrial and satellite, although satellite speeds do not currently meet the 25/3 MbPS standard and can not accommodate data-intensive applications such as HD video streaming, voice over IP, virtual private networks, telemedicine, real-time distance learning and two-way video conferencing
- **Mobile broadband** is not actually a 'broadband' connection. 'Mobile broadband' is a term used by mobile phone operators as a synonym referring to internet access over their existing mobile networks

- These networks use cell towers which transmit data to and from a user's mobile phone, and 'mobile broadband' is simply the way of accessing the internet over this connection
- **Mobile broadband** powers smartphones, wearable devices, and **mobile health monitoring** but issues include **latency** (the time it takes to deliver a packet of data) and **consistency** (service drops)
- **Fixed and mobile broadband are not currently "substitute services"** - the decision to rely exclusively on less expensive mobile is frequently driven by **financial necessity**
- Those using mobile exclusively are more likely to hit **data-allowance limits** and **less likely to own a computer or tablet**, have a **bank account** or **health insurance\***

\*<https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2016-broadband-progress-report>



- Approximately **925,000** Virginia residents had no access to broadband at speeds needed for telehealth as of June 2016
- In Bedford **26%** of the total population did not have access; about **3%** of the urban and **46%** of the rural population had no access



Bedford County, VA	
Total Population:	71,292
Pop Density (pop/mi <sup>2</sup> ):	94.67466938
Per Capita Income:	\$28,548
Total Pop w/o Access:	26,054
% Urban Pop w/o Access:	2.75%
% Rural Pop w/o Access:	45.61%



**Map Layers**  
 Areas without population are shown without color.

- Fixed broadband 25/3 (Mbps)
- No fixed broadband 25/3 (Mbps)

The map shows where fixed residential broadband of at least 25 Mbps upload is deployed while the graph shows the fraction of the population without access

<https://www.fcc.gov/reportsch/maps/fixd-broadband-deployment-data/#lat=38.323343&lon=-79.255371&zoom=9-resear>

**JOINT SUBCOMMITTEE ON WIRELESS COMMUNICATIONS INFRASTRUCTURE**  
HOUSE AND SENATE COMMERCE AND LABOR COMMITTEES  
SENATE GENERAL LAWS AND TECHNOLOGY COMMITTEE

- The Virginia Joint Subcommittee on Wireless Communications Infrastructure is working on language regarding zoning issues related to the build-out of wireless infrastructure in the Commonwealth
- Applications for new or expanded existing infrastructure (towers, antennae, etc.) are approved by localities in accordance with state and federal law
- The state language addresses restrictions by localities and the Department of Transportation regarding the use of public rights-of-way, or easements, and specifies when a permittee may be required to relocate wireless support structures
- Industry representatives expressed a preference for uniform zoning requirements throughout the Commonwealth, in order to promote efficient statewide networks and to reduce costs
- Countervailing issues include different needs of localities and between the needs of rural and non-rural areas that lack wireless service

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- Since 1985, the Lifeline program has provided a discount on phone service and more recently broadband for qualifying low-income consumers to ensure that all Americans are able to connect to jobs, family and emergency services\*
- The FCC modernized and reformed its Lifeline program in 2016 to support stand-alone broadband service as well as bundled voice and data service packages\*\*
- The current subsidy is \$9.25 per household per month

- Individuals who qualify include those:
  - With Income at or Below 135% of the Federal Poverty Guidelines and/or those who qualify for:
    - Supplemental Nutrition Assistance Program
    - Supplemental Security Income
    - Federal Public Housing Assistance
    - Tribal-specific programs
    - Temporary Assistance for Needy Families
    - Food Distribution Program on Indian Reservations Head Start
    - Veterans Pension and Survivors Benefit Programs

\*<https://www.fcc.gov/general/lifeline-program-low-income-consumers>

\*\*<https://www.fcc.gov/document/fcc-modernizes-lifeline-program-digital-age>

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## FCC UNIVERSAL SERVICE RURAL HEALTH CARE PROGRAMS

• The FCC’s universal service health care programs include:

- **The Rural Health Care Telecommunications Program**
  - Established in 1997, the Telecommunications Program ensures that eligible rural HCPs pay no more than their urban counterparts for telecommunications services
- **The Rural Health Care Pilot Program**
  - Provides enhanced funding to help public and non-profit health care providers deploy broadband for telehealth and telemedicine funds up to 85% of the costs of deploying those networks - Virginia participants include:
    - West Virginia Telehealth Alliance (WV,VA, OH)
    - Mountain States Health Alliance (TN,VA)
    - Virginia Acute Stroke Telehealth Project
  - The pilot is currently closed to new members

Eligible public/non-profit Health care Providers include:

- Post-secondary educational institutions offering health care instruction, including teaching hospitals and medical schools
- Community health centers or health centers providing care to migrants
- Local health departments or agencies
- Community mental health centers
- Not-for-profit hospitals
- Dedicated EDs in rural for-profit hospitals
- Rural health care clinics
- Part-time eligible entities located in facilities that are ineligible

<https://www.fcc.gov/consumers/guides/fcc%E2%80%99s-universal-service-rural-health-care-programs>

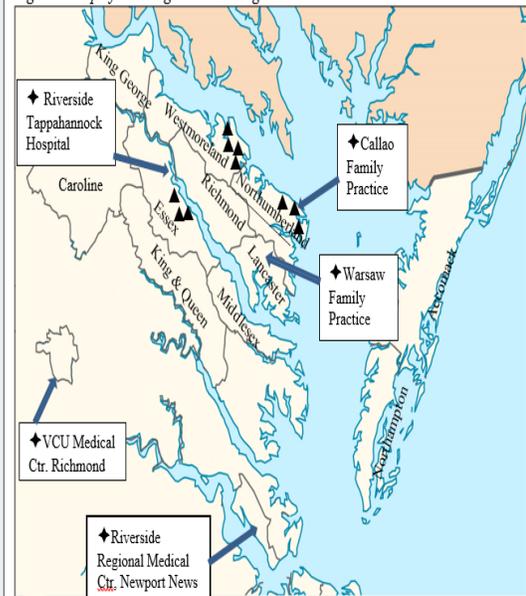


### School-Based Telehealth Initiative

- 10 school-based health centers linked via telehealth to local and regional primary care and specialty providers and therapists
- Clinical services include care and treatment for behavioral health, asthma, obesity prevention/reduction, diabetes, and oral health
- Funded by the U.S. Department of Health and Human Services, Resources and Services Administration, the Federal Office of Rural Health Policy and the Office for the Advancement of Telehealth; \$1.2M over four years from September 1, 2016 through August 31, 2020

Essex County Schools	Northumberland County Schools	Westmoreland County Schools
Essex Elementary	Northumberland Elementary	Cople Elementary
Essex Intermediate	Northumberland Middle	Washington District Elementary
Essex High	Northumberland High	Montross Middle
		Washington and Lee High

Figure 1 Map of the Target Service Region



KEY: ◆ Destination sites ▲ Rural Originating Sites (10 Schools)



## E-BACKPAC

- **Lead Organization:** University of Virginia
- **Originating Sites:** Bland County Elementary School & Bland County High School, Albert Harris Elementary School & Martinsville High School
- **Provider/Distant Sites:** Bland County Medical Clinic; Mt. Rogers Community Services Board, Bassett Family Practice, Piedmont Community Services Board, University of Virginia Health System and Office of Telemedicine UVA Children's Hospital; UVA Department of Psychiatry, UVA Teen and Young Adult Clinic; Virginia Institute of Autism
- **Target Population:** K-12 student population of Bland County and Martinsville's Albert Harris and Martinsville High Schools

- **Federal Funder:** Department of Health and Human Services and the HRSA Offices of Rural Health Policy and Advancement of Telehealth
- **Award:** \$1,178,455 September 2016 - August 2020
- **Increase access to primary and specialty care** for children in Bland County and Martinsville through telehealth-enabled School Based Health Centers
- **Establish mobile technology facilitated virtual care networks** between parents/caregivers, classroom teachers/school personnel, and clinicians to **improve communication/care coordination** for children with special health care needs
- **Increase capacity to address the needs of children** with asthma, diabetes, obesity, and behavioral health concerns through technology-assisted training education and support services
- **Incentivize healthy behaviors** related to fitness, nutrition, and oral health care through mobile health technologies designed to entertain, educate, and engage students in friendly competition and self-monitoring

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## MENTAL HEALTH SERVICES IN THE COMMONWEALTH IN THE 21<sup>ST</sup> CENTURY TELEMENTAL HEALTH SUB-GROUP REPORT

### Study Framework



The telemental health sub-group identified:

- Six barriers to expanding telemental health
- 29 options
- Twelve recommendations based on the potential for high impact and ability to achieve within a 12-month period
- Six recommendations involved tasks for the Secretary of Health and Human Resources involving access to the internet, professional/legal barriers, professional education, and services in jails
- Today's focus is on recommendations that are either in progress and need new resources, involve budget amendments and/or actions that can be taken in the 2018 GA session

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## BARRIERS TO EXPANDING TELEMENTAL HEALTH

### Provider Barriers

- Discomfort with the technology
- Skepticism/uncertainty about the impact of technology on establishing rapport with patients
- Concerns about clinical workflows
- Concerns that providing telehealth services will not be profitable and may cost the provider
- Lack of clarity regarding policies

### Workforce Barriers

- Limited access in rural and underserved communities
- Professional workforce shortages and maldistribution leads to patients with severe mental health problems being served by non-mental health professionals

### Financial Barriers

- Sustainability of telehealth services, including barriers related to public and private insurance reimbursement
- Limitations on the scope of reimbursement; fee schedules may not cover costs
- Lack of a mechanism for delivering care to those who are uninsured or underinsured

### Client/Patient Barriers

- Lack of access to high-speed internet services
- Lack of access to, or discomfort with, using technology
- Stigma associated with seeking behavioral health treatment

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## BARRIERS TO EXPANDING TELEMENTAL HEALTH, CONT'D.

### Policy Barriers

- Laws and regulations must be updated to ensure that they adequately accommodate new technology-enabled models of care, including
  - The Ryan Haight Act
  - Access to electronic medical records
  - Ensuring professionals can practice to the full extent of their education and licenses
  - Standards for out-of-state telemental health providers
  - Ensure patients have access to recommended formulary and continuity of medications during transitions

### Preventive Care Barriers

- Models that enable the use of a broad range of mental/behavioral health providers that can deliver care in a variety of settings (schools, primary care, home, workplace, nursing homes, assisted living facilities, etc.)
- Awareness of telemental health prevention services in the health care setting, the community and the criminal justice system

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## RECOMMENDATIONS FOR THE OFFICE OF THE SECRETARY OF HEALTH AND HUMAN RESOURCES (OSHHR)

- Several of the recommendations included requesting OSHHR review; the JCHC sent a letter to OSHHR on April 28, 2017 with the requests, which included:
  - Identify ways to leverage existing Commonwealth broadband and FCC/Universal Services Administrative Company Program efforts to increase access in rural and underserved areas
  - Provide policy clarification and guidance regarding liability/malpractice, privacy and security requirements, standards of care, and standards for technology and interoperability using *The Guide to the Issues* developed by the Georgia Public Policy Foundation\* as a model
  - Establish clinical fellowships in telemental health
  - Leverage existing resources through public-private partnerships to train and compensate a pool of clinicians to serve uninsured/underinsured populations and identify an interoperable portal/platform and process that would enable providers to join the pool
  - Develop a plan to facilitate the better use of telemental health servicers throughout the criminal justice system
  - A letter of request was sent from the JCHC to the OSHHR who in turn forwarded the request to appropriate agencies within the Secretariat

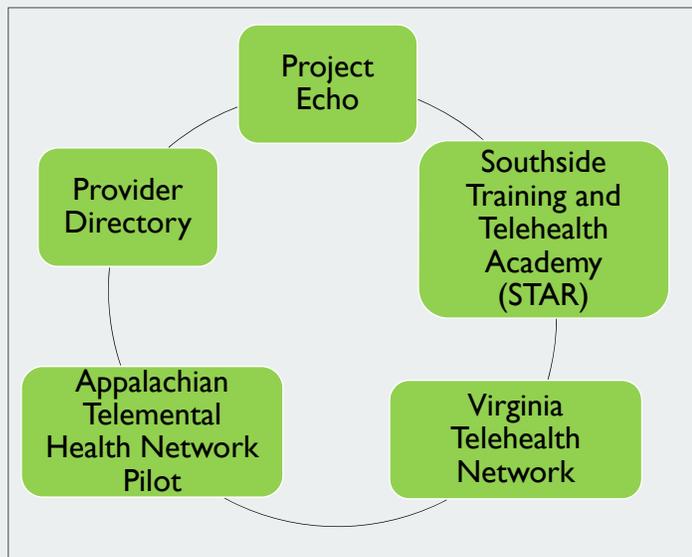
\* <http://www.georgiapolicy.org/additional-links/guidetotheissues/>



## RECOMMENDATION NOS. 2, 3, & 5: ADDRESSING TELEMENTAL HEALTH BARRIERS

### Issues:

- Many primary care providers are not trained to treat patients with Behavioral/Substance Use Disorders and may feel uncomfortable managing such patients
- As a result, primary care providers may wish to refer patients with complex issues to specialists
- However, there is a lack of specialists to whom patients can be referred in many areas
- Primary care providers need resources to help manage and/or refer patients appropriately



**RECOMMENDATION #2 - APPALACHIA TELEMENTAL HEALTH NETWORK PILOT\***

- The aims of the pilot are to expand and enhance access to quality affordable mental health services in Appalachia, allowing for efficient, early and accurate diagnoses, and reduced travel time and costs
- The Appalachian Tele-Mental Health Network would be a regional broadband health network using an interoperable, standards-based system to allow for multiple vendor platforms
- The network pilot will assess broadband infrastructure throughout the region to close gaps; develop partnerships with regional providers, clinics, hospitals, public health institutes and institutes of higher education; and, explore innovation through the development and testing of new technologies

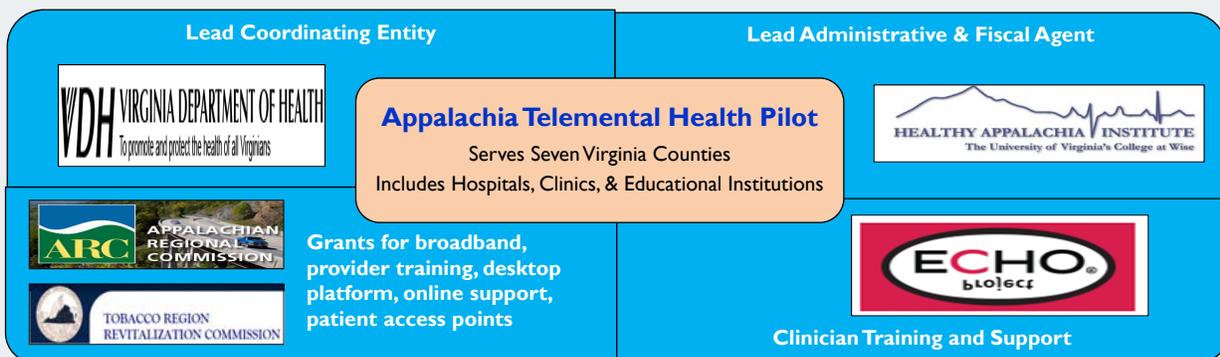
- Support and develop regional partnerships and pilot projects
- Provide evidence for telehealth policy change
- Develop a readiness assessment tool for providers

- Support telehealth training opportunities
- Assess market dynamics by state, including reimbursement rates, and payer source
- Create online referral network and resource center for providers and professionals

\*Appalachian Tele-Mental Health Network; Mental Health and Substance Abuse Disparities in Appalachia



**RECOMMENDATION #2  
ESTABLISH THE APPALACHIA TELEMENTAL HEALTH NETWORK PILOT**



The Southwest Virginia Health Authority seeks to improve quality of life in the region by enhancing, fostering and creating opportunities that advance health status and provide health-related economic benefits for people of all ages\*

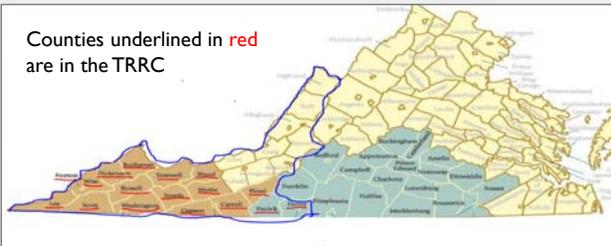
\*<http://www.vrha.org/weekly/articles/Blueprint.pdf>



## RECOMMENDATION #2 APPALACHIA TELEMENTAL HEALTH NETWORK PILOT, CONT'D.

- The Sub-Commission report recommends that the Commonwealth leverage funding to implement a pilot telemental health network using Appalachian Regional Commission (AEC) and Tobacco Region Revitalization Commission (TRRC) grants, which have overlapping footprints
- There are 25 Virginia counties that qualify for ARC funds, of which 16 also qualify for TRRC funds (Bland, Buchanan, Carroll, Dickenson, Floyd, Grayson, Henry, Lee, Patrick, Russell, Scott, Smyth, Tazewell, Washington, Wise and Wythe)
- Tasks would include:
  - developing a readiness assessment tool to determine current resources, network capability, knowledge and telehealth technology needs for providers as they join the network

- Create an on-line referral network/directory that will allow providers to display their credentials, specialties and state license information
  - Providers can be identified by patients based on “next available appointment”, patient rating, patient satisfaction, years in the network, etc.
- As part of the network/directory, providers will have access to compiled provider information, resources and advice on using telehealth within their practice, recommended equipment, and continuing education opportunities



\*Appalachian Tele-Mental Health Network; Mental Health and Substance Abuse Disparities in Appalachia



## RECOMMENDATION #3: PROJECT ECHO

- Establish a statewide Project ECHO (Extension for Community Healthcare Outcomes) focused on mental/behavioral health issues such as pain management, behavioral health disorders, substance use disorders (including opioid use) and other addictions
- The ECHO model™ links expert specialist teams at an academic ‘hub’ with primary care clinicians in local communities – the ‘spokes’ of the model
- Together, they participate in virtual grand rounds, combined with mentoring and patient case presentations
- Project Echo sessions allow for a team of specialists to consult on de-identified patient cases via video conferencing to primary care and other providers across the state
- Sessions include a didactic section on pre-determined topics (including medication assisted treatment for substance use), and continuing medical education credits are available



- This model fosters knowledge sharing, collaboration, building up the confidence and capacity of providers
- Project ECHO has been successful in raising the comfort level of PCPs to appropriately manage patients in the primary care setting and/or refer them to specialists
- Project ECHO has been used for a variety of health care issues and can be expanded over time to include other disorders
- Providers can participate over a computer and smart phone



## WORLDWIDE PROJECT ECHO LOCATIONS



### Moving Knowledge, Not Patients

Through telementoring, ECHO creates access to high-quality specialty care serving local communities.



Hub and spoke knowledge-sharing networks create a learning loop:

Community providers learn from specialists.

Community providers learn from each other.

Specialists learn from community providers as best practices emerge.



## PROJECT ECHO, CONT'D.

- Other activities can include recruitment of physicians to participate in the [DATA-2000 wavier](#) training for prescribing buprenorphine for opioid use disorder
- Data 2000 is part of the Children's Health Act of 2000 which permits physicians who meet certain qualifications to treat opioid dependency with narcotic medications approved by the Food and Drug Administration, including buprenorphine in treatment settings other than opioid treatment programs

### Substance use disorder curriculum from the New Mexico integrated addictions and psychiatry ECHO clinic includes:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Alcohol &amp; opioid use disorder and management of withdrawal</li> <li>• Tobacco use disorder</li> <li>• Benzodiazepine use disorder</li> <li>• Cannabis use disorder</li> <li>• Synthetic drugs (bath salts/spice)</li> <li>• Identifying &amp; treating dual-diagnosis</li> </ul> | <ul style="list-style-type: none"> <li>• Challenging conversations in treatment of SUD</li> <li>• Stigma and stigma busting</li> <li>• Seeking safety</li> <li>• Community reinforcement approach</li> <li>• Motivational interviewing</li> <li>• Science of urine drug monitoring</li> <li>• Relapse prevention</li> </ul> |
|---|---|



## VIRGINIA PROJECT ECHO

- The **Virginia Department of Health** received a **one-year SAMHSA grant** to start Project ECHO in Virginia
  - VDH will provide technical assistance, direction and oversight in partnership with DMAS
  - Virginia staff received training at the University of New Mexico (UNM) in 2017
  - The program will utilize a software platform developed at UNM provided at no charge
- The project will **launch in the Fall of 2017** and include three hub partners (**University of Virginia, Virginia Commonwealth University School of Medicine and Virginia Tech-Carilion**) that will provide subject matter experts for didactic training and clinical guidance on addiction disorders with plans for expanding topic areas over time
- Hubs will also oversee the rotation of specialists, curriculum development, physical site hosting and contribute evaluation scientists who will work with UNM to evaluate the program
- **Sustained funding of \$300,000 per year** is needed to continue and expand the program beyond the first year and three existing hubs and pay for office space, administrative costs, payment to hub providers, technology, equipment and connectivity fees

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## RECOMMENDATION #5

**APPROPRIATE \$50,000 ANNUALLY TO THE VIRGINIA TELEHEALTH NETWORK (VTN) TO ESTABLISH AND MANAGE A REFERRAL NETWORK OF VIRGINIA-LICENSED TELEMENTAL HEALTH PROVIDERS**

**The VTN devotes its resources to advancing the adoption, implementation, and integration of telehealth and related technologies statewide and promotes the coordination and delivery of care for all Virginians**

- General Fund dollars would go to:
  - Establishing, maintaining and managing the provider directory
  - Outreach to clinicians to be trained in setting up and managing a telehealth practice
- Providers could receive technical and management training through STAR Telehealth Certification Trainings
- Additional ongoing funding may be required for sustainability but could come from a variety of sources (e.g., private/public partnerships)

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VHWA

STAR is a partnership of the New College Institute and the University of Virginia, Center for Telehealth. STAR is supported by funds through grant T55HP202B5 from the Health Resources and Services Administration at the Virginia Health Workforce Development Authority.

The Southside Telehealth Training Academy and Resource Center (STAR) is a training program that is part of the Virginia Health Workforce Development Authority located in Martinsville for health care providers seeking to use advanced telemedicine and telehealth systems for rural and medically-underserved populations; Programs include:

- **Board Certified Telemental Health Provider training for mental health professionals includes:**
  - Crisis Management
  - Settings and Care Coordination
  - Direct-to-Consumer legal and ethical requirements
  - Orienting Clients
  - Choosing and Using Technology
- **Certified Telemedicine Clinical Presenter training**
  - Telemedicine Essentials
  - Live Video/Store, Foreword, Remote Monitoring
  - Consultation Protocols
  - Video Conferencing Etiquette & Record Keeping
- **Certified Telehealth Coordinator/Technical Professional**
  - Technology Used & Live Interaction Visit
  - The Telehealth Coordinator and Team
  - Clinical Basics and Working with the Presenter
  - Remote Patient Monitoring
- **HIPPA training**
  - Purpose of HIPPA & HIPPA Standards
  - Identifying Breach Scenarios
  - How to be HIPPA Compliant
  - Business Associates Agreements
  - Penalties and Fines Related to Breaches
  - Role of HIPPA Audits

The STAR platform, website and content were created in 2012 and need to be expanded and updated; the Telemental Health Sub-committee estimates that \$100,000 would be needed to accomplish these goals

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### RECOMMENDATION #11

#### HAVE JCHC STUDY THE COSTS/BENEFITS OF DIFFERENT MODELS FOR CONTRACTING TELEMENTAL PROVIDERS SERVING THE COMMUNITY SERVICES BOARDS (CSB)

- **Issues:**
  - How to maximize economies of scale and efficiency in providing telepsychiatry services across the Commonwealth
  - Some CSBs only have enough work for a few hours per week making contracting less efficient, whereas a centralized model could employ full-time staff to serve the state or large region within the state
- **Current Model**
  - Each CSB is responsible for developing their individual telepsychiatry services model and providers
- **Centralized Model**
  - Psychiatrists are hired by the Department of Behavioral Health and Developmental Services to meet the demands of all the CSBs statewide or by region
  - There are many private and for-profit companies that provide telepsychiatry services or behavioral health services organizations (BSO) that might be used
  - CSBs could contribute funds, based on utilization

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POLICY OPTIONS

Option 1	Take no action
Option 2	The JCHC supports the Mental Health in the 21 <sup>st</sup> Century Commission if it chooses to introduce Budget language in the 2018 session to appropriate \$300,000 per year to operate Project Echo
Option 3	The JCHC supports the Mental Health in the 21 <sup>st</sup> Century Commission if it chooses to support the use of Virginia Tobacco Region Revitalization Commission and Appalachian Regional Commission funds to create an Appalachian Telemental Health Network Pilot
Option 4	The JCHC supports the Mental Health in the 21 <sup>st</sup> Century Commission if it chooses to introduce Budget language in the 2018 session to appropriate \$50,000 to create a state-wide on-line network directory of tele mental health providers
Option 5	The JCHC supports the Mental Health in the 21 <sup>st</sup> Century Commission if it chooses to introduce Budget language in the 2018 session to appropriate \$100,000 to update and expand the Southwest Training Academy and Resource Center telehealth website, platform and content



Written public comments on the proposed options may be submitted to JCHC by close of business on September 8, 2016.

Comments may be submitted via:

- ❖ E-mail: [jchcpubliccomments@jchc.virginia.gov](mailto:jchcpubliccomments@jchc.virginia.gov)
- ❖ Fax: 804-786-5538
- ❖ Mail: Joint Commission on Health Care
- ❖ P.O. Box 1322
- ❖ Richmond, Virginia 23218

Comments will be provided to Commission members and summarized during the JCHC's November 21<sup>st</sup> decision matrix meeting.

(All public comments are subject to FOIA release of records)



**APPENDIX A:  
MEDICARE REQUIREMENTS WAIVED FOR SELECT MODELS AND DEMONSTRATIONS**

Requirement	Change in Medicare telehealth requirement under waiver	Applicable models and demonstrations
Originating site geography	This waiver removes the requirement that telehealth only occur in <ul style="list-style-type: none"> <li>a rural health professional shortage area,</li> <li>a county that is not included in a Metropolitan Statistical Area, or</li> <li>an entity that participates in a federal telehealth demonstration project (referred to as telemedicine demonstration projects in statute) approved by or receiving funding from the Secretary of Health and Human Services as of December 31, 2000.</li> </ul>	Bundled Payments for Care Improvement Model <sup>a</sup> Comprehensive Care for Joint Replacement Model Episode Payment Models <sup>b</sup> Next Generation Accountable Care Organizations
Originating site type	The waiver allows for telehealth services to be furnished in the patient's home or place of residence and eliminates the requirement that the patient receiving telehealth services must be at one of the specified originating sites: <ul style="list-style-type: none"> <li>physician or provider office,</li> <li>critical access hospital,</li> <li>rural health clinic,</li> <li>federally qualified health center,</li> <li>hospital,</li> <li>hospital-based or critical access hospital-based renal dialysis center or satellites,</li> <li>skilled nursing facility, or</li> <li>community mental health center.</li> </ul> The waiver eliminates the requirement to pay originating site fees when telehealth services are provided in the patient's home.	Comprehensive Care for Joint Replacement Model Episode Payment Models <sup>b</sup> Next Generation Accountable Care Organizations
Originating site facility fee	The waiver allows participants to receive cost-based payment for telehealth when they are the originating site, rather than the approximately \$25 set fee for originating sites.	Frontier Community Health Integration Project Demonstration

Source: GAO analysis of Medicare statute and Centers for Medicare & Medicaid Services (CMS) regulations. | GAO-17-365

Note: The term "originating site" refers to the location where the patient is located while receiving a telehealth service.

<sup>a</sup>The Bundled Payments for Care Improvement Model refers in this case only to Bundled Payments for Care Improvement models two and three.

<sup>b</sup>Episode Payment Models refer to three models for episodes of care surrounding (1) acute myocardial infarction, (2) coronary artery bypass graft, and (3) surgical hip/femur fracture treatment. CMS officials told us that these models would begin sometime in calendar year 2017.

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EPSTEIN  
BECKER  
GREEN

**Appendix B: 50-State Survey of Telemental/Behavioral Health (2016)**



50-State Survey of Telemental/Telebehavioral Health  
**VIRGINIA**

EPSTEIN  
BECKER  
GREEN

**What is the definition of "telemedicine" or "telehealth"?**

Virginia defines "telemedicine services" as "the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment." This does not include an audio-only telephone, electronic mail message, or facsimile transmission.

[VA CODE ANN. § 38.2-3418.16\(b\).](#)

"Telemedicine is the real-time or near real time two-way transfer of medical data and information using an interactive audio/video connection for the purposes of medical diagnosis and treatment."

[Virginia Department of Medical Assistance Services, Physician/Practitioner Manual, ch. IV \(Covered Services and Limitations\), p. 25 \(rev. July 31, 2015\).](#)

**What is the definition of "telemental," "telebehavioral," and "telepsychiatry"?**

None identified.

**PSYCHIATRISTS**

**What is the regulatory body in the state that governs the practice of psychiatry?**

[Virginia Board of Medicine](#)

**What are the restrictions on the scope of practice for psychiatrists practicing via telemedicine/telehealth?**

"A practitioner is discouraged from rendering medical advice and/or care using telemedicine services without (1) fully verifying and authenticating the location and, to the extent possible, confirming the identity of the requesting patient; (2) disclosing and validating the practitioner's identity and applicable credential(s); 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 services. An appropriate practitioner-patient relationship has not been established when the identity of the practitioner may be unknown to the patient."

[Virginia Board of Medicine, Guidance Document 85-12 \(Telemedicine\) \(adopted Feb. 19, 2015\).](#)

**Are there any licensing requirements specific to telemedicine/telehealth (e.g., requirements to be licensed in the state where the patient is located)?**

None identified.

However a license issued by the Virginia Board of Medicine is generally required to practice as a psychiatrist in Virginia.

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**What are the criteria for establishing a practitioner-patient relationship via telemedicine/telehealth?**

"[A] practitioner using telemedicine services in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the practitioner-patient relationship as defined in [Va. Code Ann.] [§ 54.1-3303](#) and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine services as a component of, or in lieu of, in-person provision of medical care, while others are not. The practitioner is responsible for making this determination, and in doing so must adhere to applicable laws and standards of care."

[Virginia Board of Medicine, Guidance Document 85-12 \(Telemedicine\) \(adopted Feb. 19, 2015\).](#)

**Does a psychiatrist have prescribing authority?  
If so, under what conditions/limits may a psychiatrist prescribe via telemedicine/telehealth?**

Yes.

"For purposes of this section, a bona fide practitioner-patient-pharmacist relationship is one in which a practitioner prescribes, and a pharmacist dispenses, controlled substances in good faith to his patient for a medicinal or therapeutic purpose within the course of his professional practice. In addition, a bona fide practitioner-patient relationship means that the practitioner shall (i) ensure that a medical or drug history is obtained; (ii) provide information to the patient about the benefits and risks of the drug being prescribed; (iii) perform or have performed an appropriate examination of the patient, either physically or by the use of instrumentation and diagnostic equipment through which images and medical records may be transmitted electronically; except for medical emergencies, the examination of the patient shall have been performed by the practitioner himself, within the group in which he practices, or by a consulting practitioner prior to issuing a prescription; and (iv) initiate additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects."

[VA CODE ANN. § 54.1-3303.](#)

"Prescribing medications, in-person or via telemedicine services, is at the professional discretion of the prescribing practitioner. The indication, appropriateness, and safety considerations for each prescription provided via telemedicine services must be evaluated by the practitioner in accordance with applicable law and current standards of practice and consequently carries the same professional accountability as prescriptions delivered during an in-person encounter. Where such measures are upheld, and the appropriate clinical consideration is carried out and documented, the practitioner may exercise their judgment and prescribe medications as part of telemedicine encounters in accordance with applicable state and federal law."

"Prescriptions must comply with the requirements set out in Virginia Code §§ 54.1-3408.01 and 54.1-3303(A) as amended by HB 2063. Additionally, practitioners issuing prescriptions as part of telemedicine services should include direct contact for the prescriber or the prescriber's agent on the prescription. This direct contact information ensures ease of access by pharmacists to clarify prescription orders, and further facilitates the prescriber-patient-pharmacist relationship."

[Virginia Board of Medicine, Guidance Document 85-12 \(Telemedicine\) \(adopted Feb. 19, 2015\).](#)

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**What are the acceptable modalities (e.g., telephone, video) for the practice of psychiatry via telemedicine/telehealth that meet the standard of care for the state?**

The term "telemedicine services" does not include an audio-only telephone, electronic mail message, facsimile transmission, or online questionnaire."

[VA CODE ANN. § 38.2-3418.16\(b\).](#)

**PSYCHOLOGISTS**

**What is the regulatory body in the state that governs the practice of psychology?**

[Virginia Board of Psychology](#)

**What are the restrictions on the scope of practice for psychologists practicing via telemedicine/telehealth?**

None identified.

**Are there any licensing requirements specific to telemedicine/telehealth (e.g., requirements to be licensed in the state where the patient is located)?**

None identified.

However, a license issued by the Virginia Board of Psychology is generally required to practice as a psychologist in Virginia.

Virginia has certain exemptions from the licensure requirements, including for "[a]ny psychologist holding a license or certificate in another state, the District of Columbia, or a United States territory or foreign jurisdiction when in Virginia temporarily and such psychologist has been issued a temporary license by the Board to participate in continuing education programs or rendering psychological services without compensation to any patient of any clinic which is organized in whole or in part for the delivery of health care services without charge as provided in § 54.1-106."

[VA CODE ANN. § 54.1-3601\(7\).](#)

**What are the criteria for establishing a practitioner-patient relationship via telemedicine/telehealth?**

None identified.

**Does a psychologist have prescribing authority?  
If so, under what conditions/limits may a psychologist prescribe via telemedicine/telehealth?**

No.

[VA CODE ANN. § 54.1-3602.](#)

**What are the acceptable modalities (e.g., telephone, video) for the practice of psychology via telemedicine/telehealth that meet the standard of care for the state?**

None identified.

See Psychiatrists section above.

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<b>SOCIAL WORKERS</b>	
<b>What is the regulatory body in the state that governs the practice of social work?</b>	<a href="#">Virginia Board of Social Work</a>
<b>What are the restrictions on the scope of practice for social workers practicing via telemedicine/telehealth?</b>	None identified.
<b>Are there any licensing requirements specific to telemedicine/telehealth (e.g., requirements to be licensed in the state where the patient is located)?</b>	<p>"A social worker providing services to a client located in Virginia through technology-assisted therapy must be licensed by the Virginia Board of Social Work."</p> <p><a href="#">Virginia Board of Social Work, Guidance Document 140-3 (Guidance on Technology-Assisted Therapy and the Use of Social Media) (adopted Oct. 25, 2013).</a></p>
<b>What are the criteria for establishing a practitioner-patient relationship via telemedicine/telehealth?</b>	<p>None identified.</p> <p>However, a social worker must "inform clients of potential risks and benefits of services and the limitations on confidentiality and ensure that clients have provided informed written consent to treatment."</p> <p><a href="#">18 VA ADMIN. CODE § 140-20-150.</a></p>
<b>Does a social worker have prescribing authority? If so, under what conditions/limits may a social worker prescribe via telemedicine/telehealth?</b>	No.
<b>What are the acceptable modalities (e.g., telephone, video) for the practice of social work via telemedicine/telehealth that meet the standard of care for the state?</b>	None identified.
<b>COUNSELORS</b>	
<b>What is the regulatory body in the state that governs the practice of counseling?</b>	<a href="#">Virginia Board of Counseling</a>

<b>What are the restrictions on the scope of practice for counselors practicing via telemedicine/telehealth?</b>	<p>"Regardless of the delivery method, whether in person, by phone or electronically, these standards [18 VA ADMIN. CODE § 115-20-130] shall apply to the practice of counseling."</p> <p>"Counseling is best in the traditional sense, in person in a face-to-face relationship, in the same room. Counseling may be continued using technology-assisted means after it is initiated in a traditional setting. Counseling that from the outset is delivered in a technology-assisted manner is less than desirable in that issues of the counseling relationship, client identity and other issues may be compromised."</p> <p><a href="#">Virginia Board of Counseling, Guidance Document 115-1.4 (Guidance on Technology-Assisted Counseling and Technology-Assisted Supervision) (adopted Aug. 8, 2008).</a></p>
<b>Are there any licensing requirements specific to telemedicine/telehealth (e.g., requirements to be licensed in the state where the patient is located)?</b>	<p>None identified.</p> <p>However, a license issued by the Virginia Board of Counseling is generally required to practice as a counselor in Virginia.</p>
<b>What are the criteria for establishing a practitioner-patient relationship via telemedicine/telehealth?</b>	None identified.
<b>Does a counselor have prescribing authority? If so, under what conditions/limits may a counselor prescribe via telemedicine/telehealth?</b>	No.
<b>What are the acceptable modalities (e.g., telephone, video) for the practice of counseling via telemedicine/telehealth that meet the standard of care for the state?</b>	<p>None identified.</p> <p>See Psychiatrists section above.</p>
<b>MARRIAGE/FAMILY THERAPISTS</b>	
<b>What is the regulatory body in the state that governs the practice of marriage/family therapy?</b>	<a href="#">Virginia Board of Counseling</a>
<b>What are the restrictions on the scope of practice for marriage/family therapists practicing via telemedicine/telehealth?</b>	None identified.

<p><b>Are there any licensing requirements specific to telemedicine/telehealth (e.g., requirements to be licensed in the state where the patient is located)?</b></p> <p>None identified. However, a license issued by the Virginia Board of Counseling is generally required to practice as a marriage and family therapist in Virginia.</p>	
<p><b>What are the criteria for establishing a practitioner-patient relationship via telemedicine/telehealth?</b></p> <p>None identified. Marriage and family therapists must inform clients of the purposes, goals, techniques, procedures, limitations, potential risks, and benefits of services to be performed, the limitations of confidentiality, and other pertinent information when counseling is initiated, and throughout the counseling process, as necessary. Marriage and family therapists also must provide clients with accurate information regarding the implications of diagnosis, the intended use of tests and reports, fees, and billing arrangements.</p> <p><a href="#">18 VA ADMIN CODE § 115-50-110.</a></p>	
<p><b>Does a marriage/family therapist have prescribing authority? If so, under what conditions/limits may a marriage/family therapist prescribe via telemedicine/telehealth?</b></p> <p>No.</p>	
<p><b>What are the acceptable modalities (e.g., telephone, video) for the practice of marriage/family therapy via telemedicine/telehealth that meet the standard of care for the state?</b></p> <p>None identified.</p>	
<p><b>ADVANCED PRACTICE REGISTERED NURSES (APRNs)</b></p>	
<p><b>What is the regulatory body in the state that governs the practice of advanced practice nursing?</b></p> <p><a href="#">Virginia Board of Nursing</a></p>	
<p><b>What are the restrictions on the scope of practice for APRNs practicing via telemedicine/telehealth?</b></p> <p>None identified.</p>	
<p><b>Are there any licensing requirements specific to telemedicine/telehealth (e.g., requirements to be licensed in the state where the patient is located)?</b></p> <p>None identified. However "a license to practice registered nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in such party state. A license to practice licensed practical nursing issued by a home state to a resident in that state will be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical nurse in such party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws."</p> <p><a href="#">VA CODE ANN. § 54.1-3032.</a></p>	

<p><b>What are the criteria for establishing a practitioner-patient relationship via telemedicine/telehealth?</b></p> <p>None identified.</p>	
<p><b>Does an APRN have prescribing authority? If so, under what conditions/limits may an APRN prescribe via telemedicine/telehealth?</b></p> <p>Yes. <i>See Psychiatrists section above (regarding telehealth-specific conditions/limits).</i></p>	
<p><b>What are the acceptable modalities (e.g., telephone, video) for the practice of advance practice nursing via telemedicine/telehealth that meet the standard of care for the state?</b></p> <p>None identified. <i>See Psychiatrists section above.</i></p>	
<p><b>PRIVACY/CONFIDENTIALITY</b></p>	
<p><b>Are there privacy/confidentiality requirements specifically related to telemental/telebehavioral/telepsychiatric health services?</b></p> <p>None identified.</p>	
<p><b>MINORS</b></p>	
<p><b>What are the requirements/restrictions regarding the provision of telemental/telebehavioral/telepsychiatric health services to minors?</b></p> <p>None identified.</p>	
<p><b>FOLLOW-UP CARE</b></p>	
<p><b>What are the requirements regarding follow-up care for telemental/telebehavioral/telepsychiatric health services?</b></p> <p>One of the requirements of having a bona fide physician-patient relationship is to "initiate additional interventions and follow-up care, if necessary, especially if a prescribed drug may have serious side effects" when providing care through telemedicine.</p> <p><a href="#">VA CODE ANN. § 54.1-3303.</a></p>	
<p><b>Are there requirements regarding the time frame in which a follow up face-to-face encounter would be required in a telemental/telebehavioral/telepsychiatric health setting? If so, what are those requirements?</b></p> <p>None identified.</p>	

## COVERAGE & REIMBURSEMENT

### Does the state have a parity statute in place mandating coverage by private insurers for telemedicine/telehealth services (including telemental/telebehavioral/telepsychiatric health services) on par with those provided in face-to-face/in-person encounters?

Yes.

"[E]ach insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the cost of such health care services provided through telemedicine services, as provided in this section."

"An insurer, corporation, or health maintenance organization shall not exclude a service for coverage solely because the service is provided through telemedicine services and is not provided through face-to-face consultation or contact between a health care provider and a patient for services appropriately provided through telemedicine services."

[VA. CODE ANN. § 38.2-3418.16\(A\) & \(C\).](#)

### Are there provisions requiring certain reimbursement levels/amounts for telemedicine/telehealth services (including telemental/telebehavioral/telepsychiatric health services)?

None identified.

### Does Medicaid provide coverage for telemental/telebehavioral/telepsychiatric health services? If so, what are the coverage criteria?

Yes.

Coverage is available for all Virginia Medicaid recipients, irrespective of whether recipients have Medicaid fee-for-service or Medicaid managed care organization coverage.

Eligible services:

- Office visits
- Individual psychotherapy
- Family psychotherapy
- Group psychotherapy
- Colposcopy
- Fetal non-stress test
- Obstetric ultrasound
- Fetal echocardiography
- Cardiography interpretation and report only
- Echocardiography
- Speech therapy services
- Radiology and radiology related procedures

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### Does Medicaid provide coverage for telemental/telebehavioral/telepsychiatric health services? If so, what are the coverage criteria? CONTINUED

- Remote imaging for detection of diabetic retinopathy; remote imaging for monitoring and management of diabetic retinopathy with physician review, interpretation and report
- Remote imaging using fundus photography for monitoring and management of diabetic retinopathy, with interpretation
- Crisis intervention

Eligible providers:

- Physicians
- Nurse practitioners
- Nurse midwives
- Clinical nurse specialists
- Clinical psychologists
- Clinical social workers
- Licensed professional counselors
- Speech pathologists (speech therapy only)

[Virginia Department of Medical Assistance Services, Physician/Practitioner Manual, ch. V \(Billing Instructions\), pp. 21-26 \(rev. July 31, 2015\).](#)

## CONTROLLED SUBSTANCES

### How are "controlled substances" defined by the state?

Virginia statutes define "controlled substance" to mean "a drug, substance, or immediate precursor in Schedules I through VI. The term shall not include distilled spirits, wine, malt beverages, or tobacco as those terms are defined or used in Title 3.2 or Title 4.1. The term 'controlled substance' includes a controlled substance analog that has been placed into Schedule I or II by the Board pursuant to the regulatory authority in subsection D of [Va. Code Ann.] § [54.1-3443](#)."

[VA. CODE ANN. § 54.1-3401.](#)

### What are the requirements/laws governing the prescribing of "controlled" substances?"

"A prescription for a controlled substance may be issued only by a practitioner of medicine . . . who is authorized to prescribe controlled substances, or by a licensed nurse practitioner pursuant to [Va. Code Ann.] § [54.1-2957.01](#), a licensed physician assistant pursuant to [Va. Code Ann.] § [54.1-2952.1](#), or a TPA-certified optometrist pursuant to Article 5 [Va. Code Ann.] § [54.1-3222](#) et seq.). The prescription shall be issued for a medicinal or therapeutic purpose and may be issued only to persons . . . with whom the practitioner has a bona fide practitioner-patient relationship."

[VA. CODE ANN. § 54.1-3303.](#)

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## APPENDIX C: FEDERAL TELEHEALTH RULES SUMMARY APRIL 2017

**Table 1: Summary of Federal Agency Telehealth Services and Originating Sites**

Federal agency	Telehealth services	Originating sites
Centers for Medicare & Medicaid Services (CMS)	Medicare	Medicare pays for the 81 telehealth services on CMS's list of telehealth services as of 2016.
	Medicaid	Services covered differ depending on the state. According to CMS officials, CMS does not have any statutory or regulatory requirements for telehealth use in Medicaid.
Department of Defense (DOD)	DOD does not limit the services allowed for telehealth use within its direct care component. <sup>5</sup>	Outside of military treatment facilities, originating sites are allowed at patient locations that are deemed appropriate by the treating provider in DOD's direct care component, including the patient's home. According to officials, telehealth services are not limited to certain geographic areas, such as rural locations.
Department of Veterans Affairs (VA)	According to officials, VA does not limit the services providers can offer via telehealth.	According to officials, VA does not limit the locations where telehealth services may be offered.

<http://www.gao.gov/assets/690/684115.pdf>

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## APPENDIX B: FEDERAL TELEHEALTH RULES SUMMARY APRIL 2017, CONT'D

**Table 2: Medicare Telehealth Requirements Waived for Selected Models and Demonstrations**

Requirement	Change in Medicare telehealth requirement under waiver	Applicable models and demonstrations
Originating site geography	This waiver removes the requirement that telehealth only occur in <ul style="list-style-type: none"> <li>a rural health professional shortage area,</li> <li>a county that is not included in a Metropolitan Statistical Area, or</li> <li>an entity that participates in a federal telehealth demonstration project (referred to as telemedicine demonstration projects in statute) approved by or receiving funding from the Secretary of Health and Human Services as of December 31, 2000.</li> </ul>	Bundled Payments for Care Improvement Model <sup>a</sup> Comprehensive Care for Joint Replacement Model Episode Payment Models <sup>b</sup> Next Generation Accountable Care Organizations
Originating site type	The waiver allows for telehealth services to be furnished in the patient's home or place of residence and eliminates the requirement that the patient receiving telehealth services must be at one of the specified originating sites: <ul style="list-style-type: none"> <li>physician or provider office,</li> <li>critical access hospital,</li> <li>rural health clinic,</li> <li>federally qualified health center,</li> <li>hospital,</li> <li>hospital-based or critical access hospital-based renal dialysis center or satellites,</li> <li>skilled nursing facility, or</li> <li>community mental health center.</li> </ul> The waiver eliminates the requirement to pay originating site fees when telehealth services are provided in the patient's home.	Comprehensive Care for Joint Replacement Model Episode Payment Models <sup>b</sup> Next Generation Accountable Care Organizations
Originating site facility fee	The waiver allows participants to receive cost-based payment for telehealth when they are the originating site, rather than the approximately \$25 set fee for originating sites.	Frontier Community Health Integration Project Demonstration

Source: GAO analysis of Medicare statute and Centers for Medicare & Medicaid Services (CMS) regulations. | GAO-17-365

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Appendix D

**United States Code Title 40 Subtitle IV—Appalachian Regional Development**

**Sec. 14509. High-speed broadband deployment initiative**

- (a) In General- The Appalachian Regional Commission may provide technical assistance, make grants, enter into contracts, or otherwise provide amounts to individuals or entities in the Appalachian region for projects and activities--
- (1) to increase affordable access to broadband networks throughout the Appalachian region;
  - (2) to conduct research, analysis, and training to increase broadband adoption efforts in the Appalachian region;
  - (3) to provide technology assets, including computers, smartboards, and video projectors to educational systems throughout the Appalachian region;
  - (4) to increase distance learning opportunities throughout the Appalachian region;
  - (5) to increase the use of telehealth technologies in the Appalachian region; and
  - (6) to promote e-commerce applications in the Appalachian region.
- (b) Limitation on Available Amounts- Of the cost of any activity eligible for a grant under this section--
- (1) not more than 50 percent may be provided from amounts appropriated to carry out this section; and

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**APPENDIX E: NUMBER OF DATA 2000 CERTIFIED PHYSICIANS BY LOCATION IN VIRGINIA 2016**

Abingdon	6	Charlottesville	8	Fort Belvoir	7	Marion	2	Powhatan	1	Stafford	6
Abingdon	3	Charlottesville	1	Fredericksburg	7	Marshall	1	Purcellville	1	Staunton	2
Alberta	1	Chesapeake	10	Front Royal	4	Mc Lean	1	Quinton	1	Sterling	5
Alexandria	24	Chesterfield	11	Gainesville	2	Mclean	2	Radford	1	Suffolk	3
Appalachia	2	Christiansburg	7	Gordonsville	1	Mechanicsville	1	Raven	2	Vienna	2
Arlington	10	Colonial Heights	1	Hampton	15	Midlothian	8	Reston	1	Virginia Beach	35
Ashburn	4	Covington	2	Harrisonburg	2	Nassawadox	1	Richmond	56	Warrenton	2
Big Stone Gap	2	Culpeper	4	Henrico	3	Newport News	10	Richmond	1	Williamsburg	8
Blacksburg	7	Danville	3	Herndon	1	Norfolk	7	Roanoke	23	Willis	1
Bristol	3	Duffield	5	Hopewell	3	North Chesterfield	1	Rocky Mount	1	Winchester	9
Burke	2	Dumfries	2	Lebanon	3	Norton	1	Saint Charles	1	Wise	2
Cedar Bluff	2	Exmore	1	Leesburg	4	Oakton	1	Salem	11	Woodbridge	6
Centerville	2	Fairfax	18	Lorton	1	Parksley	2	Saltville	2	Wytheville	4
Centerville	4	Falls Church	14	Lynchburg	11	Petersburg	2	South Hill	2	Yorktown	1
Centerville	1	Farmville	1	Lynchburg	1	Portsmouth	6	South Riding	1	<b>Grand Total</b>	<b>477</b>
Chantilly	1	Fishersville	2	Manassas	6	Pound	2	Springfield	3		

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## VIRGINIA STATE BUDGET

2017 Session

### Budget Amendments - HB1500 (Conference Report)

Bill Order » Item 30 #1c

**Study to Expand Telemental Health Services (language only)**

#### **Language**

Page 21, after line 5, insert: "The Joint Commission on Health Care shall study options for increasing the use of telemental health services in the Commonwealth. The Joint Commission on Health Care shall specifically study the issues and recommendations related to telemental health services set forth in the report of the Service System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century. All agencies of the Commonwealth shall provide assistance to the Joint Commission on Health Care for this study, upon request. The Joint Commission on Health Care shall submit an interim report to the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century by November 1, 2017 and a final report of its findings to the Joint Subcommittee by November 1, 2018."

#### **Explanation**

(This amendment directs the Joint Commission on Health Care to study options for increasing the use of telemental health services in the Commonwealth. The Joint Commission on Health Care shall specifically study the issues and recommendations set forth in the report of the Service System Structure and Financing Work Group of the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century. The Joint Commission on Health Care shall provide an interim report to the Joint Subcommittee Studying Mental Health Services in the Commonwealth in the 21st Century by November 1, 2017, and shall submit a final report with findings by November 1, 2018.)