North Dakota Law Review

Volume 73 | Number 1 Article 10

1997

Telemedicine: The Intersection of Law, Medicine, and Technology

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TELEMEDICINE: THE INTERSECTION OF LAW, MEDICINE, AND TECHNOLOGY

DISCUSSION PANEL*

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* Special thanks to Ruth Ann Johnson—without her transcription efforts and willingness to go the extra mile to get the transcript to the editor, this project would have taken many more weeks to complete.

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In August of 1996, Dr. Nickelson completed his fellowship, and continued to serve Senator Conrad as a Legislative Assistant. In January of 1997, Dr. Nickelson took a position as the Special Assistant to the Executive Director of the Practice Directorate at the APA, where he assists in the integration and coordination of the diverse agenda of professional psychology on both the state and federal level.

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In 1994, Ms. Anderson received the Outstanding North Dakota Rural Health Professional Award from Mercer-Oliver Health Services. In 1996, Ms. Anderson was chosen as one of the Most Influential People in Telemedicine by the Center for Public Service Commission. She has been a presenter at various health conferences, including the 1995 North Dakota Rural Health Conference.

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Ms. Gilbert received her American law degree from Loyola University's Chicago School of Law. She is now the Chair of the Legal and Regulatory Issues Task Force for the American Telemedicine Association. Ms. Gilbert is on the editorial advisory board for the Community Medical Network Society (COMNET) and Telemedlaw. She has written and lectured over 100 times on high technology and health care information legal issues in the United States, the United Kingdom, Canada, and France.

PHYLLIS GRANADE, ESQ.[4]
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DR. NICKELSON: Before I start, I'd like to thank the University of North Dakota Law Review members, and in particular, Ms. Brenda Foyt, who put this symposium together. They've done an absolutely wonderful job.

Throughout the weekend we have had assembled right here one of the best collective brain trusts in the area of telehealth. When you combine that with the participating providers and attorneys, some of whom represent two of the strongest telehealth networks in the nation—which are located right here in North Dakota—we have an opportunity to talk about some of the tough issues facing the development of telehealth technology and networks, with an eye toward formulating solutions that work for everybody. Because if they don't work for somebody, they are here and can raise their hand and say, "I don't

4. Phyllis F. Granade is an associate with the Atlanta office of Kilpatrick & Stockton in Atlanta, Georgia, and works in the Health Care Practice division. She received her B.A., *cum laude*, Phi Kappa Phi, from the University of Georgia and received her J.D. from the University of South Carolina School of Law. She is a member of the South Carolina and Georgia Bar Associations. Ms. Granade was formerly a legal consultant to the Medical College of Georgia Telemedicine Center, and has researched the issues of malpractice, licensure, credentialing, and privacy as these issues relate to telemedicine. Her article *Malpractice Issues Affecting the Implementation of Telemedicine* was published by the Western Governors' Association as part of its TELEMEDICINE ACTION REPORT BACKGROUND PAPERS.

Ms. Granade participated in the Augusta Conference, to which she submitted an article regarding licensure issues. Ms. Grande was a speaker for the Georgia Statewide Telemedicine Program Conference. She has also spoken before the Federation of State Medical Boards regarding telemedicine and physician licensing. Ms. Granade recently spoke at conferences regarding malpractice and security issues for medical practice on the Internet and the legal issues associated with computer-based patient records.

5. Paul Orbuch is counsel to the Western Governors' Association in Denver, Colorado, where he focuses on policy in the areas of international trade and relations, federalism, natural resources, and telemedicine. He also teaches for the University of Denver's Environmental Policy and Management Program.

Previously, Mr. Orbuch was a staff attorney with the Center for International Environmental Law (CIEL) in Washington, D.C., and was an adjunct professor of law at American University's Washington College of Law. He is co-editor of *Trade and the Environment: Law, Economics and Policy* and is co-author of a number of legal articles that focus on links between the environment and international trade. Prior to joining CIEL, Mr. Orbuch was an associate with the Washington, D.C. law firm of Howery & Simon in their international trade group and was a staff member of the President's Industry Policy Advisory Committee for Trade and Policy Matters. He is a graduate of the University of California, Hastings College of Law, and the University of California Los Angeles.

6. Dr. Puskin is currently the Acting Director of the Federal Office of Rural Health Policy (ORHP). In that capacity, Dr. Puskin serves as Executive Secretary of the National Advisory Committee on Rural Health, and manages policy developments in that office. Dr. Puskin oversees ORHP's managed care initiatives and all of its telemedicine programs, programs that have provided over $19 million dollars for telemedicine demonstrations over the past seven years. Prior to assuming her current position in 1988, she served as the Deputy Director.

In 1993, Dr. Puskin co-chaired the Rural Work Group of the White House Health Care Reform Task Force. She currently serves as an advisor to the Congressional Ad Hoc Committee on Telehealth and the National Security Telecommunications Advisory Committee. Dr. Puskin received her Sc.D. degree from John Hopkins University School of Hygiene and Public Health, an M.S. degree from the University of Rochester School of Medicine and Dentistry, and B.A. and M.A. degrees from Boston University.

think that will work for me as a provider or a regulator, and here is why."

Before we begin, I'd like to talk about some of the developments that other presenters and participants have raised during this symposium. There is a real consensus about what the critical issues facing the continued development of telehealth networks are: developing reimbursement and revenue streams; building additional telecommunications infrastructure and reducing rates; facilitating interstate practice and licensure, and the evolution of malpractice protections that might reflect the potentially unique aspects of telehealth practice. Over the past few years, this entire panel has participated in conferences, drafted legislation, and contributed to numerous reports that have attempted to address these issues, issues that the Western Governor's Association in fact identified over two years ago.[7]

In my mind, the recent reemergence of telehealth and telemedicine is really only a reflection of broader changes in our culture and our health care system about how information is exchanged and used in making decisions. These changes reflect a convergence of many factors on the ultimate goal of providing the most cost-effective and appropriate care as possible under all conditions. Telehealth is just a real-time expression of this convergence—it is in no way a unique phenomenon. In an effort to reach that elusive goal, we're using technology, economic theory, radically new information systems, strict clinical guidelines and protocols, and exploring new means of communication between the administrators and the providers that have a responsibility for, and a stake in, the success of these new systems.

A good indicator of this convergence is the recent increase in federal funding for telehealth. According to the General Accounting Office (GAO), the federal government spent approximately $646 million on telehealth programs between 1994 and 1996.[8] One quarter of that money is used by the Department of Defense (DOD), but the rest is in the authority of many disparate federal agencies and programs, one of which is represented on this panel.

I'd like to start with the issue of reimbursement through Medicare, Medicaid, and other insurances for telehealth services because revenue streams are what folks are most interested in seeing develop quickly. You've heard a lot of different perspectives about revenue streams, including that they may not be the be all and the end all that many say they are, and that a Medicare or Medicaid revenue stream may not be the

7. *See* WESTERN GOVERNOR'S ASS'N, TELEMEDICINE ACTION REPORT (1995) (identifying the barriers to telemedicine).

8. U.S. GENERAL ACCOUNTING OFFICE, No. NSIAD/HEHS 97-67, TELEMEDICINE: FEDERAL STRATEGY NEEDED TO GUIDE INVESTMENTS (1997).

only way to jump-start telehealth system development and stimulate new clinical applications.

Senator Kent Conrad of North Dakota, as many of you know, introduced a bill in the 104th Congress that dealt with some of the issues raised here this weekend.[9] The foremost issue the Senator wished to address was the current lack of Medicare reimbursement for telehealth services. His bill, for the first time in any federal legislation, set a date by which Medicare is to begin reimbursing for telehealth services.[10] Previous telehealth bills asked the Health Care Financing Administration (HCFA) only to finish their study and report back to Congress the method or formula that it might use to reimburse for Medicare telehealth sometime in the future.[11] The goal of the Senator's bill was to actually get HCFA to begin to pay for these services, not just study them. Politically, the bill accomplished something significant; it resulted in the Office of Management and Budget (OMB) granting a Medicare waiver to the HCFA telehealth reimbursement research project, which had been languishing in agency limbo for almost eighteen months. It also gave the Joint Working Group on Telemedicine some exposure and perhaps a shot at becoming the central planning point for federal telehealth activities.

The first task I would like the panel to assess is whether they think the current political climate is favorable to the passage of such a provision. Worth noting is that one of the most obvious applications of this technology is to rural areas like the State of North Dakota, that the Senate Finance Committee is populated almost entirely by members from heavily rural states, and that this specific bill has been referred to the Finance Committee. I'd ask anybody who has an opinion to just dive on in here and tell us what you think.

DR. PUSKIN: As you already alluded to, as of March of this year, HCFA is required to come out with a report saying how they will reimburse for telemedicine.[12] They're not likely to make that report deadline—but they must have something as a matter of clearance.

Let us step back and look at reimbursement. We need to clarify what currently is being paid for and what is not. What you are really talking about, and what Senator Conrad's bill really addresses, is fee-for-service Medicare reimbursement.

9. The Comprehensive Telehealth Act of 1996, S. 2171, 104th Cong. (1996). This bill has been reintroduced as the Comprehensive Telehealth Act of 1997, S. 385, 105th Cong. (1997), and the Improved Access for Telehealth Act of 1997, H.R. 966, 105th Cong. (1997).

10. S. 2171 § 101.

11. *See, e.g.*, Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 § 192, 1996 U.S.C.C.A.N. (110 Stat.) 1936, 1988 (codified in scattered sections of 42 U.S.C.A.); S. 963, 104th Cong. § 4 (1995).

12. Health Insurance Portability and Accountability Act § 192.

Currently Medicare pays for some telemedicine procedures that do not ordinarily involve face-to-face contact under standard medical practices: radiology, EKG interpretation, and other kinds of procedures where ordinarily the patient does not have to be in the same room and the doctor doesn't have to lay hands on the patient. They represent a significant segment of overall health care services.

Medicare also pays for the use of telemedicine under Medicare managed care or risk-based contracts. If you're a managed care plan, for a set fee, you are required to supply all the care a Medicare patient may need in a month. Medicare has said if a plan wants to use telemedicine, it's their decision regarding the clinical appropriateness and cost efficiency of telemedicine, and if they want to take on all the legal issues, that's their problem. Basically, Medicare is willing to allow you to use your managed care allotments on telemedicine. In fact, they probably aren't aware of when Medicare managed care is actually using telemedicine.

However, only about 9.5% of Medicare beneficiaries are enrolled in Medicare managed care plans, which is a very small part of the Medicare market. So the real question is, can we expect fee-for-service telemedicine payments from Medicare in the foreseeable future?

DR. NICKELSON: If I'm a rural practitioner, that's where up to eighty percent of my revenue stream is.

DR. PUSKIN: That's right, that's where your livelihood is. At this point in time, in demonstration sites in four states, Medicare will be paying for fee-for-service telemedicine under some very restrictive conditions, conditions that I would argue are not the most conducive to efficient clinical practice.

Under these demonstrations, there must be a practitioner at each end, and while you may have heard earlier that the future lies in the use of store and forward technology, this demonstration requires that they be interactive consults. HCFA wants to evaluate at least a portion of Medicare payment policy—how to pay for telemedicine and what the costs might be. They will probably quite legitimately argue that there are significant technical issues around how to pay for interactive services under Medicare.

HCFA is also very concerned, as is Congress—even all those rural Senators on the Finance Committee—about whether telemedicine will impose additional costs on the Medicare Trust Fund. There's talk about the Medicare Trust Fund running out of money in the near future. At a time when you're talking about reducing payments to practitioners in real dollars, you've got a tough sell ahead when you argue you have a new technology that you now want covered that most likely will cost the Medicare Trust Fund money by increasing access to care. To keep that

from happening, HCFA is effectively holding telemedicine to a higher standard.

DR. NICKELSON: A standard requiring proof of both the cost-effectiveness and clinical appropriateness of telehealth services before any payment will be considered?

DR. PUSKIN: Yes, or at least a demonstration of what the added value is. These arguments are shared by a lot of political people when they start looking at the bottom line for Medicare. Recognizing that, you say, "Well, what is the political balance here for the Medicare program?" I couldn't predict at this point; I couldn't give you a clue.

DR. NICKELSON: I don't think leadership on either side of the aisle, in either chamber, could either.

DR. PUSKIN: Right. What I think may happen is that there will be an increase in the pressure to speed up and broaden the scope of HCFA's demonstration programs by paying for and including data from other federally funded telemedicine demonstration programs. There are a lot of people out there that say, "HCFA is not going to get enough data in those states to show anything. So why not broaden it to allot more payments to more demonstrations?"

DR. NICKELSON: Are you arguing that demonstrations that have come through the Office of Rural Health Policy (ORHP), the Rural Utility Service (RUS), and other non-HCFA demonstrations would be appropriate places to expand the HCFA demonstrations for the sake of getting even more data?

DR. PUSKIN: That might be some of the legislative thrust, as opposed to a blanket "here's how we're going to reimburse telemedicine" formula. I'm trying to give you a little bit of a crystal ball here. I think this may be a credible possibility in the legislative process in the coming year.

DR. NICKELSON: Is there something that someone like Carla or Sheri [Frueh][13] or some of the other providers in the audience here could do that would help move the issue of Medicare payment in ways that would be beneficial to them, perhaps by asking their legislators to try to get their telehealth networks included in the HCFA program? My question is, does the current fee-for-service HCFA demonstration, and the data that it is likely to generate, really reflect your experience? Does it respond to the services you really have to provide out there?

MS. ANDERSON: It's data that projects like ours [the Dakota Telemedicine System] already have. My telemedicine system has completed over 500 consults, and we've got the data. We did try to get into the HCFA demonstration project; however, we were told that we

13. Telemedicine Coordinator, St. Alexis Medical Center, Bismarck, North Dakota.

started our project one month too late to participate. So the data is out there and it comes from projects in systems like ours that serve a large elderly population and which substantiate both Medicare needs and overall health care system savings in rural areas.

DR. NICKELSON: So you agree with Dr. Puskin, that by combining more of the existing data that we already have, we could leverage HCFA to begin paying sooner rather than later?

DR. PUSKIN: I think the issue is that the HCFA demonstrations are using a particular evaluation scheme that has been approved by OMB, one that relies on prospective data. OMB has said that they're not going to look at retrospective data, although I'd argue that to do so that might be helpful in making the case.

I suggested earlier that federal Medicare is not always a leader in payment policy. Everyone thinks it's a 10,000 pound gorilla, right? The Medicare budget is bigger than most nation's. But, in reality, if you look at the history of Medicare payment in the last ten years, Medicare has not led policy—the private sector has.

DR. NICKELSON: For example, the recent announcement by North Dakota Blue Cross Blue Shield that it will begin to pay for telehealth consultations?

DR. PUSKIN: Exactly. Getting private insurers and managed care plans involved so that telemedicine, or at least certain aspects of telemedicine, become integrated into standard clinical practice. When this happens, the pressure on Medicare to cover it becomes enormous. That's why if we can get the American Medical Association (AMA) to develop and adopt telemedicine Current Procedural Terminology (CPT) reimbursement codes, many clinical telemedicine activities will begin to take on the appearance of standard clinical practices and pathways. For providers in the audience, I'll remind you that the AMA looked at adopting special CPT codes for telemedicine last summer and they did not do it. Asking them to revisit their decision is important; it is the equivalent of giving telemedicine the "Good Housekeeping Seal of Approval."

Interestingly, even though Medicare pays for it, we don't have much telepathology. Part of the reason is that physicians want to control the slides, and most of the remote stage microscope telemedicine systems available now are very costly. This is an example of a nonfinancial barrier—it reflects a human variable, not a payment variable—and points out how important it is to take established practice patterns into account when introducing telehealth systems to uninitiated providers.

DR. NICKELSON: What does this mean for you folks in the audience? I think of the two North Dakota telehealth systems that I

know—do you have codes in your system so that you can track your telemedicine usage?

MS. ANDERSON: We track our codes using the evaluation and management (E&M) codes. That's what Medicaid of North Dakota has approved for payment. Right off the bat we sent a letter to North Dakota Medicaid and they immediately approved reimbursement; however, most of our Medicaid participants also have Medicare as their primary carrier. North Dakota Blue Cross Blue Shield, as of two weeks ago, approved telemedicine underneath the E&M codes also, but they do not require a telemedicine modifier on those codes.

To date, for the consults that we have done, we have tracked them using the E&M codes, and have put a modifier on it ourselves to make sure that we track them accurately. When we received notification from North Dakota Blue Cross Blue Shield, I talked with HCFA to find out how we could forward these Medicare denials into Blue Shield. I was put in contact with a woman who said that Medicare will give us a modifier to use on our codes so that they do get denied. Essentially, Medicare is giving us a modifier to be able track these Blue Shield codes, so it's something that once they're approved for reimbursement, I imagine they will put into place anyway.

DR. NICKELSON: So you're really developing this clinically appropriate revenue stream indirectly?

MS. ANDERSON: Yes, indirectly.

MS. GRANADE: My suggestion is that if you want to start with a government agency, no need to start with a 10,000 pound gorilla—start with a 1,000 pound gorilla—go after state level Medicaid agencies and payment policies. If Medicaid in each of the states begins to reimburse telemedicine services, then you'll see others follow. It's already been done, or is being done, in California under implementation of the Telemedicine Development Act of 1996 which requires MediCal to develop a reimbursement plan.[14] I personally think a great place for telemedicine to develop is in skilled nursing facilities. The vast majority of reimbursement for our nursing homes is through Medicaid at the state level.

DR. NICKELSON: Are we looking at established CPT codes at the state Medicaid level? Are there Medicaid codes that could take us through an evaluation cycle and demonstrate the establishment of standard clinical practices?

DR. PUSKIN: Ten states now cover telemedicine under Medicaid. They each have coding schemes, and some even use the same coding

14. S. 1665, 1995-96 Reg. Sess. § 9 (Cal. 1996) (codified at CAL. WELF. & INST. CODE § 14132.72(c) (West Supp. 1997)).

scheme. Nancy Ellory, the Director of the Montana Medicaid program, is a very outspoken advocate about the advantages of telemedicine to state Medicaid programs. She talks about savings to patients and the system by simply reducing transportation costs.

I think Medicaid presents a wonderful laboratory and I anticipate seeing more and more states deciding to cover it in the next two years. The issue comes down to changing the prevailing perspective that Medicare is the leader and, therefore, without Medicare you can't do anything. I would suggest to telemedicine programs that in the end they are going to have to pull Medicare payments in for long-term survival, but to realize that Medicare could in fact be the last payer to change its policy.

Some of the discussion this weekend has centered around home care. I want to point out that Medicare has said that home care will be the last thing that will receive telemedicine reimbursement, even though home care appears to be one of the more promising areas for telemedicine to provide clinically appropriate and cost-effective care. I would also suggest that there are other payers that pay for home care, including private insurance, who could begin to gather data that might be very significant in forcing the issue of the coverage and cost-effectiveness of home care.

DR. NICKELSON: I'm beginning to hear some consensus on strategy: developing new CPT codes that establish new practice patterns within Medicare; working with what we have in state Medicaid programs that are already paying; tracking utilization and cost data in both systems; and maybe getting into the Medicare payment stream through means other than legislative mandate.

DR. PUSKIN: What Dr. Bill Goodall didn't say when he presented earlier this weekend is that the Allina Health system has tracked all of it's emergency telecare visits with codes and determined what the Medicare and private insurance fees would have been. He's created a database which he hopes to use to convince third party payers about the cost-effectiveness of emergency telecare coverage.

Again, I believe that if you can provide solid information about standard telemedicine practice and overall cost savings, you almost force third party payers to pay. You also have leverage with employers, who after all, are really footing the bill. If you see it that way, you really have a broader revenue stream to influence and access than just Medicare.

DR. NICKELSON: Some of this is bringing payers into the system and letting them know that this is a good way to provide services to their employees, whether in the workplace, which we heard Robert Waters talk about earlier this weekend, or in clinics and hospitals.

I would also like to discuss a couple of other aspects of the CPT codes. Much of what I'm hearing from HCFA and even private insurers is that they are comfortable considering payment for the clinical services part of the code, but that they will not pay for the bricks and mortar or malpractice part of the code. Yet we've heard all throughout this weekend that infrastructure and malpractice are some of the largest barriers to wide-scale development of telehealth.

As an ex-congressional health staffer, I understand concerns that maybe the Medicare Trust Fund is not the place to try to fund a health care telecommunications system. Yet isn't this, in some ways, akin to the same reasons that the overhead and malpractice aspect of the current CPT codes were instituted in the first place, to build and maintain additional hospital beds and to train additional providers to treat Medicare eligible patients? Any thoughts from the panel? Why shouldn't it be a part of that CPT code—am I committing political suicide by even thinking about including it?

MS. ANDERSON: We ourselves would like to simply get reimbursed for the services our specialists provide. In my mind, that's going to be the biggest hurdle to overcome. The issue you raise is similar to some of the issues with radiology regarding the technical versus the professional component payments.

DR. PUSKIN: Let me give you a theoretical construct. We pay physicians according to the Resource Based Relative Value System (RBRVS), a standard fee schedule that's supposed to reflect the resources consumed. In that fee schedule is presumably the full cost of doing business. So for physician practices, there are some practice costs that are in fact reflected in the fee that's paid. The argument that might be made by a third party payer is that if we can provide a service for the same cost as we if we provide the service face-to-face, that should be the level of reimbursement. But you're asking if somehow they should pay more for telemedicine?

DR. NICKELSON: I'm asking from the standpoint that I don't want them to pay less than the amount they would pay if the service were supplied face-to-face in a hospital or clinic.

DR. PUSKIN: But if they pay the standard fee, which reflects the cost of doing business, a standardized cost of doing business, is that maybe as much as you can expect in this political environment? Because we're not really using cost-based reimbursement anymore. We're moving toward cost-prospective payment. You get a set fee for a service, and that fee is not based on your own costs, but is based on what is considered a reasonable cost of doing business.

DR. NICKELSON: Before we move off of reimbursement and on to other topics, is there anything that you folks [the audience] would like to raise, while you have the panel here, about either your current situations or situations that you've thought about during this symposium?

MS. FRUEH: You were mentioning that the demonstration projects that are under way require there to be a practitioner on either end. What about behavioral telehealth—psychologists or psychiatrists—in those demonstration projects? Those particular specialties usually do not require a provider on the patient end. In fact, in light of confidentiality and other privacy concerns, state law might actually require you to allow the patient to see the provider alone.

DR. PUSKIN: You know, you ask a great question. I am not a hundred percent sure, but I think they may not be covering behavioral telehealth applications.

DR. NICKELSON: They're covering some elements of medication management, but no therapeutic applications. Unfortunately, they also felt they could not devise a way to reimburse psychologists for their services, either. Sorry. A little editorial there.

DR. PUSKIN: I think it is very limited coverage, and I don't know the details.

UNIDENTIFIED SPEAKER: Why was that decided? That makes absolutely no sense. Behavioral telehealth applications seem ideal. I mean, I'm glad they're doing something with it, but it seems obvious that they should do more.

DR. PUSKIN: Let me just suggest that there are a number of areas in this demonstration that those of us who have been doing telemedicine for a long while are troubled by. I think, on the other hand, many of us are simply pleased that they're doing anything at all.

UNIDENTIFIED SPEAKER: The California legislation,[15] as initially drafted, included some money to cover the cost of infrastructure, but that was one of the early things that got dropped, the argument being that infrastructure is simply part of the cost of doing business.

DR. NICKELSON: So you'd argue for including infrastructure costs in Medicare reimbursement for telehealth services?

UNIDENTIFIED SPEAKER: No. I think it's a cost of doing business.

DR. NICKELSON: I'm going to move on to licensure and practice across state lines. You've heard everybody agree that it's also a barrier to the development of telehealth networks, particularly telehealth systems that would like to expand across state lines.

15. *Id.*

As a caveat, when I first began examining telehealth policy, I did not have any real hands on experience with the technology. I only had my clinical, regulatory, and legal experiences to guide me—that made the licensure issue the most salient to me. The folks on this panel are the people that taught me all about both the substantive and the political realities of the issue. I can't thank them enough for the sharing of their wisdom about this and other issues, and for standing up with me when I proposed some rather radical ideas about how professional licensure could be handled in the future.

That said, we have had a lot of talk about it throughout this symposium, and I think folks have a pretty good understanding of how professional licensure works in general, and even how some of the other professions handle it.

The issue to me is, "What is the next step?" How do we take the current state-based licensure scheme and move it to a level that responds to the realities of the marketplace, a marketplace that will continue to consolidate into larger and larger multistate conglomerates that will want to create a health system where both clinical data and clinical services are communicated across state lines?

One point I'd like to raise is that licensure is not a problem with many of the federal systems that are currently using telehealth to supply clinical services. They are exempt organizations, and don't have to have to contend with the intricacies of multistate licensure. The Veterans Administration (VA), the Department of Justice, Bureau of Prisons (DOJ-BOP), the Indian Health Service (IHS), and the Department of Defense (DOD) don't concern themselves to any great extent with many licensure requirements. They can practice in any federal facility in any state within their system.

Do these exempt organizations have anything to teach us before we go about trying to put together a telehealth licensure model? Do they remind us that efforts to retain state authority may be motivated more by economic and protectionist arguments rather than a true concern about consumer safety?

DR. PUSKIN: Can I just make a quick a factual statement? If you work for the military, the Indian Health Service, or the VA, you have to hold a full and unrestricted license in at least one state, and continue to acquire the requisite number of continuing education credits required by that state to maintain your license.

DR. NICKELSON: But once you've accomplished that—

DR. PUSKIN:—you can practice anywhere within the system. Basically, they accept that if you have a license in one state, that's all you need. They do this because they have come to the conclusion that there

really isn't much difference in the substantive licensure requirements across the states and territories. One difference is that each of the federal systems enforce their own disciplinary standards. So if you just consider enforcement and disciplinary action, each federal system does its own thing, and it really is not the same kind of an issue as it is between the states. The military and the other exempt federal organizations are also working on a single credential that could apply to all practitioners in federal facilities. The question is, can you duplicate that kind of licensure in some kind of a national system?

DR. NICKELSON: While retaining the discipline function at a more local level, perhaps?

DR. PUSKIN: Yes. There are ways of splitting out the functions of licensure that would create uniform procedures and policies in terms of what's expected and implementing and monitoring some of the disciplinary enforcement on a more local level.

MS. GRANADE: One of the key things that is missing when we talk about the licensing provisions for lawyers and doctors that work in government agencies is the concept of competition. Federally employed providers and lawyers do not compete against each other in the marketplace, unlike private sector providers.

It's primarily economic reasons, in my opinion, an opinion that I believe is fairly justified from the research that I've done, that is changing state practice acts and licensure laws. As Robert Waters and a number of other speakers have mentioned, since 1993, nine states have changed their licensing laws to prohibit physicians who were attempting to practice into that state via electronic means from doing so without holding a full and unrestricted license in the state that they were entering. Those are new laws—designed to stop telemedicine—to stop the practice of teleradiology, in particular. It is argued that these laws are being changed to protect the health and safety of the citizens of that state, which is to some extent justified. However, I happen to know that in several of the states, from which I have reliable information, radiologists, who were not teleradiologists, were very influential in getting those statutes changed.

So I think it's really competition that differentiates between federal employees and their ease of licensure, and the challenges of private market state-by-state licensure.

MS. GILBERT: If you look at our profession, as lawyers we are admitted, typically, in one state, and we can practice for extended periods of time in other states without having to take the bar exam. If I physically move, say to California, yes, I'll have to take the bar exam because I'll be practicing my profession there on a permanent basis.

But if I have a case to litigate, and I'm thinking of a specific a piece of litigation I oversaw that lasted three years in another state but was handled by members of my firm, they were going back and forth, they were at times staying there, and they didn't need any special license.

MS. GRANADE: Yes. Actually, you would have to get a *pro hac vice*.[16]

MS. GILBERT: Yes, but what I mean is they didn't have to fill out a ton of papers, they didn't have to pay money, it was something that was automatic and simple and easy.

MS. GRANADE: But that kind of fits into the medical emergency and other consultation exceptions that still exist. Most of the consultation exceptions in the state say that for "episodic" or "irregular" periods, you can come in and visit.

MS. GILBERT: Yes, but do you think that a case that lasted three years and did not go to an appeal, but could have, is just a consultation?

DR. PUSKIN: Can I ask question? When you came into her state, did you have a lawyer or a firm that was a Georgia firm there as the primary representative.

DR. NICKELSON: Did you have to engage or attach some local counsel?

MS. GILBERT: We were hired by a client; the client heard about our reputation and called us to do the job. When litigation papers had to be filed in court, then yes, we needed to have local counsel.

MS. GRANADE: Yes. I think that represents an extended consultation exception. The issue, really, is—

DR. NICKELSON:—the length of the consultation.

MS. GRANADE: In the health care field they use consultation, but the different states have different time frames to determine what constitutes a consultation and how frequent those consultations can be before the provider is required to get a license. Most people here today though, wouldn't want it to be just for one case. If your firm came into a state and said, "We're going to provide legal services to twenty clients," I think it would be a very different matter.

UNIDENTIFIED SPEAKER: Yeah. However, as a citizen I feel like I have to extend the conversation beyond simply telemedicine. If a doctor has committed malpractice and has had his or her license revoked in, say, the state of Washington, and I have a son away at college in Pennsylvania, I don't want that doctor moving to Pennsylvania, getting a Pennsylvania license, and practicing on my son. The current state-based

16. To allow a lawyer to enter a jurisdiction for a particular case only. BLACK'S LAW DICTIONARY 842 (6th ed. 1991).

system gives me almost no assurance that in fact my son is being protected.

Since that is the case, it seems to me that the system is not operating for the protection of citizens. If the purpose of these laws is to protect the interests of the citizens and the interests of the citizens are really large enough to be federal interests, then maybe we need to begin to look at federal licensure.

MS. GRANADE: But how did your son find that physician in Pennsylvania who no longer possesses a license? There's a difference between the regulatory environment that tries to ensure that a person who no longer holds a license cannot practice medicine, but still is, and the fact that you can sue that person for medical malpractice and practicing without a license.

UNIDENTIFIED SPEAKER: But if [the physician] goes to Pennsylvania for one reason or another, his disciplinary record doesn't follow him.

MS. GRANADE: No, but the Federation of State Medical Boards (FSMB) has compiled a National Practitioner Databank, containing information about disciplinary actions against physicians throughout the U.S. So now you can check.

UNIDENTIFIED SPEAKER: Yet for one reason or another we're finding that doctors who are disciplined in one state are, in fact, practicing in another—

DR. NICKELSON:—and if they harm someone, they're going to get a lot of media attention.

UNIDENTIFIED SPEAKER: For those of you who aren't medically trained, I have a general point that needs to be made. The house of medicine is not unified on licensure. When the American College of Radiology takes a position, or if they try to influence state or federal legislation, it is very probable that the College of Emergency Physicians, who is unaware of what the radiologists are doing, would take a significantly different position if they were part of the debate. Even within the profession, certain factions may be protecting personal interests that another branch would not want protected. That point needs to be emphasized—if you're not familiar with the culture of medicine, you can't simply extrapolate the positions of one specialty to other aspects of medicine.

UNIDENTIFIED SPEAKER: I'd like to ask Paul [Orbuch] about the Western Governor's Association (WGA) regional outlook on licensure. Do they have any kind of position or proposal?

MR. ORBUCH: The resolution that WGA passed adopting our action report recommends that WGA look at interstate licensure

mechanisms and endorses the WGA taking action to develop a model code that each of our participating states could then consider or adopt to deal with regional interstate practice. That was the Western Governor's position at that time.

While the WGA resolution was being developed and passed, the FSMB was in the process of coming out with their own proposal, which is essentially a limited license for telemedicine for an out-of-state provider. The North Dakota legislators are now considering the FSMB proposal, but I don't think it's been adopted by any state yet.

Presently, I think the governors have to weigh a number of factors. They have in-state practitioners, such as their medical boards, who in most cases will probably say, "We don't want any outsiders having a right to practice in our state." However, they also have to weigh the interests of their rural constituents, who may be closer to an out-of-state physician than an in-state city at the far side of the state. They also have to weigh the advantages that some states may get by pooling their medical talent in a regional system. I could foresee three states getting together, states that have low physician-to-citizen ratios, who by combining all three state's physicians together would get much better access to a broad range of specialists for all the citizens of those states.

DR. NICKELSON: We heard from the North Dakota Medical Association yesterday that there is at least some political will to maybe take a crack at developing a laboratory of small states to look at harmonization and developing a regional solution.

One of the things I would like to hear from the panel and others is a discussion of just what kind of incentives the federal government could offer to encourage the development of a system like that. What would it take to get state provider boards, which are generally chosen by their governors, to start talking to each other about a regional alliance, or to maybe get a state within the WGA to become a catalyst for that laboratory?

MR. ORBUCH: I'm open to ideas on that one. I think that's a tough sell. I was talking with Dena Puskin at lunch, and we were trying to determine just what are the buttons you would push to open up a state's licensure system over the long term. Some of our thoughts were, well, if you're trying to protect citizens—and that's supposedly any governor's goal in this—what is going to make them think that they can better protect citizens than giving them more qualified physicians to chose from?

It may be that the Internet and other electronic means of getting medical advice that are out there now, and which are not being regulated at all, will eventually harm some citizens of these states. What if a citizen

went to this unregulated Internet service for health care advice because they were geographically too far away from a qualified provider, or because they couldn't access a provider across state lines through telehealth, and they relied on this unregulated health care advice and were injured as a result? If these kind of stories start coming to the governor's attention, the governor may eventually say, "If our citizens feel that they can't get quality medical care in my state, and they're reaching out to these hokey deals over the Internet, maybe the state should look to expanding the pool of resources available its citizens." One way to do that is to join with a few neighboring states to give the citizens a larger pool of qualified medical personnel to choose from.

DR. NICKELSON: Any thoughts on what would be the hard currency of exchange? Because what we're really exchanging is money, power, and control as well as altering revenue streams. How would we make these trades in a way that would be beneficial both to the citizens and the practitioners involved? Any ideas? Or is that something that nobody wants to tread on?

DR. PUSKIN: I think we know where you're going.

DR. NICKELSON: Honestly, I'm not going anywhere. I'm just looking for ideas, trying to find out if there's something we could put out in the policy arena for folks to work with.

DR. PUSKIN: It has been suggested that the Medicare program, being the 10,000 pound gorilla, and the Medicaid program being a mini gorilla, could by virtue of their regulatory power say, "We will recognize that if you have a full and unrestricted license in good standing in any state, Medicare will pay for interstate telemedicine services." Now that wouldn't mean that you couldn't get killed for practicing without a license across state lines by state statute, but that would de facto create tremendous pressure to look at changing things. Again, the fact of the matter is that Medicare is not necessarily a leader in many of these matters. Medicare prefers to say, as a first screen for reimbursements, that if you're a duly licensed practitioner, we will reimburse your practice in that state. To the folks from the North Dakota Health Department, does this sound like something that you would be interested in, or does it sound totally outrageous?

UNIDENTIFIED SPEAKER: It doesn't sound totally outrageous. One of the things happening in North Dakota right now is that some of our state's Medicaid population is actually treated outside of the state—mental illness is one example. So if I look at it from an economic standpoint, those are revenues that are already being lost because patients are going outside the state to seek care. I'm wondering if telemedicine

may be a way in which the patients could remain in the state, and that could create some competition with out-of-state providers.

DR. NICKELSON: So you are suggesting that one of the ways to do this is to look for health care revenue streams that might be leaving a state because they aren't being provided in the state, and see if telehealth could be a way to retain that payment stream in the state? Arguing that at least in some cases, by loosening up the licensure restrictions there may be economic benefits for the state? Any other thoughts from you folks out there on licensure?

MS. FOYT: To facilitate any real action regarding cross-state or national licensing, it seems to me that we will need a bigger consumer push from individuals like myself. When I'm sick, I go to the doctor and I don't really want to know—I don't really care—whether or not this doctor is licensed. I want whatever is wrong with me fixed, I want to be able to get on with the rest of my life. A few months ago I thought telemedicine licensure required something completely different from the system that we currently have in place, and as the weekend has progressed, it all seems to be getting rather circular. I think, "Well, it's the same," and then someone raises a new fact situation, and I think "It's completely different."

It also occurs to me that this is very similar to the situation with medical records. Our medical records go all over now, including across or through state lines, whether it is by mail, FedEx, or a telecommunications system. My X-rays, when they get sent by messenger, could be sent to the wrong part of the hospital, or even the state, just as easily as can something being sent electronically.

DR. NICKELSON: So you think there might be some leverage that consumers can apply to their elected policy makers? When I think about that kind of leverage, I think of the American Association of Retired Persons (AARP) and other consumer-oriented groups who would probably be very interested in seeing something happen to solve these problems.

MS. FOYT: I think a consumer push would be especially powerful in some of the smaller states. Speaking as a native North Dakotan, it seems sometimes that we have the conception that somewhere else is always better; we lose a lot of quality people because they feel that they can't get their health, education, and career needs met right here in the state. This technology could overcome some of that. It could serve to promote the high-quality medical professionals that are already within our own state; people would maybe have more confidence that they don't need to drive to Minneapolis or to Mayo to get high-quality care. They can do it here within the state, and not even lose time from work.

MS. ERJAVEC: I'd like to move it just a little bit to something else I'm hearing, that when we're talking about referrals and getting to these experts, we're really talking about going to a physician and saying, "I have a health problem—What do I do?" The provider says, "I'm not quite sure. Let me send you to Dr. X, who is the best in this field, through my telemedicine system." Licensure for that type of consultation just doesn't seem to be as great a problem as the walk-up health care kiosk that can come from four states away, where you did not first talk to your provider and ask him or her, "What do I do now?" I think that there should really be a very different level of a concern for licensure between those two scenarios. If there isn't, maybe I've missed a point.

MR. FREEMAN: Can I add something to that? Along the same lines, I think many of the new telehealth products are going to be hitting the market based both on what the consumer can afford and the urgency of the care that they are designed to address. I haven't heard that really discussed yet today—if the customer has a mole, which a provider is concerned about because if it's not diagnosed correctly it could later be found to be cancer, the urgency for the initial telemedicine consult is high, and the consumer will probably pay for or demand that service. I think the marketplace is going to drive all local providers to become telehealth providers.

MS. GRANADE: I think that's absolutely true. There are different levels of consumers, some who will prefer to get their health care over the Internet, and others who will prefer to see a doctor in person or would prefer an interactive video consultation to a specialist. The licensing laws are going to apply the same to all those physicians, and for right now that means that unless you're consulting via telemedicine to a state on a very irregular basis, you need to hold a full and unrestricted license in each state. That's the safest legal advice I can give a practitioner right now. It doesn't really matter whether it's via kiosk or an interactive consultation with a world famous cardiologist at the Mayo Clinic.

DR. NICKELSON: Is that reality for you folks out there, to be licensed in any. as many jurisdictions as you would want to see patients?

UNIDENTIFIED SPEAKER: That's very messy. I've been licensed simultaneously in a number of states, up to four or five at a time, and what I've found is that there is a lot of redundancy in the state licensure requirements. I think Bill [Goodall] said it well—we go to medical school; we graduate; we take a set of national tests; if we want to become a specialist, we take another set of national tests. In my specialty, I know that I can talk with another board certified doctor and assume that we have that same basic level of knowledge. If you layer on

managed care credentialing and hospital certification on top of that, we already fill out a million forms that prove we can do what we say we can do—work we're not paid for—just so that we're allowed to start to practice.

DR. NICKELSON: Do you mean JHACO, NCQA, and accreditation like that? They already meet this consumer protection function, and may make licensure as a means of consumer protection irrelevant? I also assume you mean credentialing that goes along with facilities as well as with providers.

UNIDENTIFIED SPEAKER: Yes.

UNIDENTIFIED SPEAKER: I'd like to make a comment. Health care treatment and payment are essentially interstate activities today. The same basic rules will have to apply throughout the country so that patients will have uniform rights and providers will have uniform obligations.

DR. PUSKIN: Can I respond quickly? I think Dr. Nickelson would share this perspective, having spent time on Capitol Hill and been involved in the policy debates in Washington regarding licensure. If you and the gentleman behind you feel this way, you need to get your voice heard. The only voices that are being heard right now in the state houses and on Capitol Hill are the voices that argue for state protectionism. Face it, at the heart of even limited licensure still beats protectionist concerns.

If people feel this way, or if there's a strong feeling among certain providers or consumer groups, your voice needs to be heard and made an important part of the debate. Right now the call for broader solutions to the licensure issue is simply not being heard.

UNIDENTIFIED SPEAKER: I think that some of the political inertia out there has to do with not looking at the science and common sense of things. Instead, we're looking at—

DR. PUSKIN:—politics!

UNIDENTIFIED SPEAKER: Exactly.

DR. NICKELSON: As somebody who is scientifically trained, and who went to work in Congress, I can tell you that science is only one of many competing ways to find the truths that underlie policy decisions. That's not to argue against the importance of science to sound policy making, but to tell you it isn't going to be the be all and end all of solving the questions.

UNIDENTIFIED SPEAKER: But that's the way the system has been and will continue to be—I guess my point is that it's hard for the uninitiated to crack into the system.

UNIDENTIFIED SPEAKER: I'm wondering if you could create a system where you only need to be licensed in one state, with a uniform agreement in place that allows you to practice in some others? The issue would be, how do you ensure that disciplinary action could be taken if you're treating a patient in North Dakota, and that patient complains to the appropriate North Dakota regulatory body, and the practitioner is physically located in South Dakota? How do you ensure that the South Dakota Medical Board will take a disciplinary action? Would a regional or multistate compact work, something akin to what the panel had proposed for the Western Governors, where the participating states would share a single disciplinary board?

DR. NICKELSON: The central question for most people is just that—how are we going to police providers as they move across the traditional regulatory boundaries.

MS. GRANADE: Let me try to answer that. That question has been answered at conferences, or, excuse me, has been asked at conferences like this before—how do you guarantee it? For all of my research, I have no idea how you guarantee it.

Perhaps it could work in a way similar to what happens to lawyers. Medicine is a lot like law—as professions they are both pretty highly regulated. For example, I'm licensed to practice law in two states, Georgia and South Carolina. If I commit legal malpractice and am disciplined or disbarred in Georgia, that action is reflected back to South Carolina, and South Carolina can also discipline or disbar me—I'll probably find myself disbarred in both states. That's also true for the practice of medicine in most states. But how you could guarantee that South Dakota wouldn't protect its own physician and ignore the complaint made by the North Dakota patient—I'm not sure how you would guarantee it.

UNIDENTIFIED SPEAKER: You answered the question partially. The other thing I'd like to ask is whether there is anything proposed concerning regional or universal enforcement or—

MS. GILBERT: Recall the FSMB proposal; they were looking for enforcement in either state. If patient filed a complaint, that complaint could be heard in the host state, but there was also action that could be taken in the home state, where the doctor resided. So they really proposed almost a dual enforcement mechanism.

DR. PUSKIN: Right. I went through some of the alternatives very quickly this morning, such as mutual recognition, which they use in the European Union and Australia. There are a number of different models on how to achieve harmonized standards and uniform disciplinary administration on a local level. Most have a mechanism whereby if you

commit an act that would lead to revocation of your license in one state, you also lose it in all the other states that were participating.

There are lots of ways of solving this problem. What's lacking is the political will to really do it and any consensus about the urgency of the need to solve it.

DR. NICKELSON: I can tell you that taking a shot right now at national licensure of any kind is politically difficult. I'm still smarting from even thinking that out loud in the wrong venues in the hallowed halls of Congress.

Let's turn to telecommunications policy and some of the issues around the high cost of telehealth telecommunications connections in rural areas. Sheri, about how much are telecommunications costs for your telehealth system per month under normal use?

MS. FRUEH: We currently have a network of twenty-five facilities in North and South Dakota. The line charges for any one facility range from about $250 a month for local clinics without a distance component, to the clinics that are a hundred miles away or more, where it's about $1500 per month. One connection to South Dakota costs us about $4000 per month. Multiply that by twenty different sites, and you'll get a rough estimate.

DR. NICKELSON: Carla, are those costs similar for your system?

MS. ANDERSON: Yes. Sheri and I compare numbers quite often, and neither one of us are getting a break. We range from around $1000 a month to $3200 a month for each of our sites.

DR. NICKELSON: North Dakota had a big role to play in the Federal Communications Commission's (FCC) recent health care advisory task force. State Senator Judy DeMers was named to that committee, where she represented rural providers in the process of deciding just what kind of break rural health care providers should get on telecommunications charges under the new Universal Service provisions of the Telecommunications Act of 1996.[17] Is the distance-sensitive question the question for you folks?

MS. ANDERSON: It's *the* question.

MR. FREEMAN: How about the availability of high-bandwidth digital lines?

MS. ANDERSON: Well, we have T1 capability, which is great. Many other states don't have the infrastructure to support T1. However, if we could get "dial-up" rates or "switch" services so that we only paid for time we were actually are on line, our costs would be significantly less. When we do medical consultations, we believe we have to stay at the full bandwidth. We drop back for educational and

17. Telecommunications Act of 1996, Pub. L. No. 104-104, 1996 U.S.C.C.A.N. (110 Stat.) 1932.

administrative things. Economically, though, it doesn't make sense for us to drop our bandwidth down to 1/4 T1, because we pay for that full T1 whether we're on line or not. Regardless of the bandwidth or time that we are using it, we pay for the full T1 line twenty-four hours per day, seven days a week.

DR. PUSKIN: Can I make a technical comment? I served on the same committee with Senator DeMers, and one of the issues that came up was whether the FCC could demand that carriers give rural educational and health care providers access to switched services. We were told by the telecommunications companies that there are very few urban areas that have switched T1, and there no rural areas with this capability. So achieving switched T1, right now, is a ways down the road.

In my opinion, the far more critical question right now is achieving distance insensitive rates. As was discussed earlier, the law says that you shall have "comparable" rates. The question really comes down to semantics—what is "comparable?" But the fact is there's a lot of resistance to creating distance insensitive rates because it goes against the traditional system that telephone companies use to set rates, which is to assign a rate to distance-based geographical bands.

MS. ANDERSON: In a state like ours, we also deal with many different telephone carriers. At one of our sites, we go through three telephone carriers to get to a site; we pay a termination charge for each carrier. So we end up paying a monthly flat rate to each telephone carrier and then the distance factor is added in.

DR. NICKELSON: How many of you use e-mail out here? Do you consider it an important clinical tool? Do you exchange clinical data that way? [A number of hands are raised.] How about Internet? How many folks use that to search for health information? [A number of hands are raised.] Dr. Puskin, could you talk about what the FCC is considering in the way of Internet access for rural education and health facilities?

DR. PUSKIN: One of the things that they are considering is ensuring basic access to the Internet in a way that a user would not need to pay a long distance toll. There's a lot of talk about using the Internet in creative ways to facilitate the work of public health departments and other basic health and welfare services.

DR. NICKELSON: What could folks here do to influence the system yet as it begins to make decisions about what services will be available and how they will be discounted? Do you folks feel it is something so vital to the way you practice or might practice in the future that you would want to get involved?

UNIDENTIFIED SPEAKER: There's a company called Montana Power Corporation that has a subsidiary in the long-distance bandwidth business. They have a network that goes from Seattle, to Minneapolis, to Calgary, Alberta, Canada, and back to Seattle. The subsidiary is interested in selling access to this network at rates lower than the telecommunications companies now charge.

DR. NICKELSON: So there are some free market solutions, courtesy of the newly deregulated telecommunications environment, that might help folks lower their rates without any more direct government intervention?

DR. PUSKIN: Let me suggest that deregulation will allow a lot of new people to get into the telecommunications business. Utility companies have fiber out there, but in the past there was no way to access it, because the utility companies couldn't resell it on the open market. This should create more competition.

I think that will be a ways off—the most immediate issue is to get some reform of the rates by the FCC. We'll have to see what the FCC decides in May of this year.

DR. NICKELSON: Let's turn quickly to malpractice. How many of you who would like to use a telehealth system live in fear of malpractice liability as the primary risk? Is it one of the strongest reasons you wouldn't take this on? [Few hands are raised.] So you don't see the malpractice risk as being particularly great?

MS. GRANADE: I'd like to hear some comments from out there. One of my points yesterday was that telemedicine is simply using telecommunications to deliver traditional health care services and information—the same legal principles are going to apply. In my opinion, the courts will simply apply traditional negligence principles to each different set of facts. Telemedicine could perhaps decrease malpractice claims, because patients are, in theory, getting earlier interventions thereby saving providers from having to do more expensive and risky interventions after a disease progressed a little further.

UNIDENTIFIED SPEAKER: I don't think it's a primary risk, but I think it's definitely a risk. If you look at the insurance data, people sue doctors who they don't have a relationship with. We all know of the incompetent hometown doctor that people just love and he never gets sued. Other doctors out there perform very competently, but due to an adverse outcome or something like that—

MS. GRANADE:—bad bedside manner?

UNIDENTIFIED SPEAKER: Yeah. This technology puts more of an impersonal print on that interaction and I wouldn't be surprised if more claims arose.

MS. GRANADE: I think that impersonal aspect is already becoming more and more common in the current health care marketplace. For example, in a managed care organization, you may see a different doctor every time you walk through the door. You're not necessarily establishing a personal relationship. From a legal perspective you're obviously establishing a physician-patient relationship, but you're not establishing a friendship or a rapport with that physician. You're a doc in a box, you're not Dr. Jones, my old family friend. But for the past twenty years we've kind of been moving away from that anyway.

UNIDENTIFIED SPEAKER: My primary concern would be, before I got involved in any telehealth consultation, for the patient. My primary concern is getting rid of that mole or having it looked at. If through the advent of telemedicine we might scrutinize a community doc who's a good friend, but who should be taken to task for an adverse outcome, that's a credit to telemedicine, not a discredit.

UNIDENTIFIED SPEAKER: I just want to comment from a consumer point of view. When I go to Dr. Wilder for that same mole and Dr. Wilder says, "You know, Jim, I really want another opinion," that's all I want to hear. If the guy I trust wants to use telehealth, God bless him. I feel better about the health of myself and my family. From a consumer standpoint, I can't imagine that if a community is educated on exactly what the capabilities can be, why they wouldn't say, "Wow, telehealth is great! They're going to take even better care of me now."

UNIDENTIFIED SPEAKER: I agree, most of the time I would want that second opinion, too, but the problem comes with over utilization. You've got to balance health and cost at the same time.

MS. GILBERT: There's one thing I'd like to say, about insurance coverage. If I were a physician, I would be concerned about having proper insurance—that the coverage I have also covers my telemedicine activities outside of my current geographical location.

MS. FRUEH: Your initial question was, "Are physicians worried about telehealth malpractice and liability?" We are just completing a survey of physicians in rural and urban areas of central and western North Dakota. The question was asked, "If you have telemedicine services available to you and you're not using them at all or only in a limited capacity, why is that?" We asked them to rank in order the top three reasons why they may not be using it very frequently. We haven't got all the surveys back in, but looking at those that have come in, there

was a high number of physicians that listed malpractice liability as the number one reason why they're not using it more.

DR. NICKELSON: I see we are rapidly running out of time, so I am going to try to summarize this very broad ranging discussion and offer a few final observations.

In the area of reimbursement, I think an advocacy strategy began to emerge from the comments of the panelists. The first part of that strategy would be establishing new practice patterns that could be tracked under modified or new CPT codes. Once providers integrate clinical telehealth service delivery into their standard clinical procedures and pathways, and we establish the existence of those patterns by tracking the use of telehealth CPT codes, HCFA will feel pressure to reimburse for Medicare services that providers and patients have, over time, come to rely on.

The second part of that strategy is to continue working with state Medicaid programs that are already paying for telehealth consultations to gather utilization data and examine the cost-savings these systems experience through the use of telehealth. A number of states already pay, and many more may be interested in paying, if the option of supplying services this way is simply brought to their attention and the cost-savings claims supported with solid data.

The final part of that strategy seemed to be the message to providers and health systems that they should not wait for Medicare to come around to create a revenue stream for telehealth services. They should be proactive in gathering clinical data and cost offset information and making the argument to third-party payers and employer purchasers that telehealth is something that consumers, patients, and employees are comfortable with, and in fact are demanding for the sake of convenience and peace of mind. I'm pleased; it is just this type of multifaceted approach that was successful in turning the tide on many legislative issues that I encountered in my short time working as a staffer at the United States Senate, and I think it has a good chance of success.

In the area of licensure, the panel seems to agree that providers have an economic interest in opposing the interstate practice of telehealth unless the provider is licensed in each state. Even more troublesome is that this economic interest is intertwined with the traditional consumer protection interest underlying most state licensure statutes. The consensus seemed to be that until the political will exists to untangle these interests, or until the evolving health care marketplace makes them a historical footnote, there will be few changes in licensure laws that will prove beneficial to telehealth.

One promising strategy is the development of multistate or regional agreements that would allow a provider, if licensed in one of the participating states, to legally practice in any of the other participating states. The panel really seemed to struggle with the question of which incentives might entice a small number of states to try this approach. Again, the discussion turned toward the impact that consumers and providers could have if they began to raise their collective voices about their need to have access to interstate telehealth services. I did not really hear any agreement about how we might monitor and discipline providers in such a system, though a multistate disciplinary board was proposed on the basis that telehealth may in fact be a form of interstate commerce, and in an effort to protect all citizens equally, the same standards should apply regardless of where the practitioner might be located.

Telecommunications infrastructure and the current high cost of high-end telecommunications connections seemed to also bring a consensus, at least on the issue that Medicare payment may not be the way to pay for infrastructure development, even in underserved and rural areas. The panel discussed the recommendations of the FCC Advisory Committee on Telecommunications and Health Care, and expressed the hope that these recommendations will be accepted and implemented by the full FCC when they vote on them in May of 1997.[18]

Finally, Ms. Granade's fine presentation earlier in this symposium made a strong argument that malpractice for telehealth services will likely be handled by courts no differently than other negligence or malpractice cases—the courts will simply apply the same principles to the new fact patterns. I'll add that I believe conflict of laws principles will settle questions of jurisdiction for interstate malpractice claims in many of the same ways that they already do for automobile accidents and other types of interstate commerce. As a provider, I would certainly feel better if I could accurately predict were I might end up defending a claim. Unfortunately, that is not in keeping with the traditions of our legal system, which must attempt to balance both fairness and efficiency

18. FEDERAL COMMUNICATIONS COMM'N, CC DOCKET NO. 96-45, FCC 97-157, REPORT AND ORDER (May 8, 1997). On May 7, 1997, as this manuscript was nearing completion, the FCC ruled on the Universal Service recommendations of the Advisory Committee on Telecommunications and Health Care regarding rural health care providers. The FCC provided that all public and private not-for-profit health care providers located in rural areas would be eligible to receive universal service support, not to exceed a total cap on expenditures from the Universal Services fund of $400 million. A health care provider may obtain telecommunications service at a transmission capacity up to and including the bandwidth equivalent of a T1 line, at rates comparable to those paid for similar services in the nearest urban area with more than 50,000 residents in the state where the rural health care provider is located. Rural health care providers will also receive support for both distance-based charges and toll-free connections to an Internet service provider. Each health care provider that lacks toll-free access to an Internet service provider may also receive the lesser of 30 hours of Internet access at local calling rates per month or a rebate of $180 per month for toll charges imposed for connecting to the Internet.

when determining where a claim should be heard and which law should apply.

One point bears repeating: regardless of your position on any of these issues, it is critical that politicians and policy makers hear from you *before* they are asked to make decisions about how to lower or remove any of these barriers. As one who investigated and responded to many constituent letters on behalf of a United States Senator, I cannot begin to tell you about the impact that one personalized letter can have.

That leads me to my final point. What these solutions really have in common are their reliance on very fallible human beings for their adoption, application, and change. Perhaps it is a bias in my training, but central to each solution is the need for people and systems to communicate effectively and to collectively embrace significant change in order for these barriers to truly be overcome.

For example, altering practice patterns in an effort to secure reimbursement acknowledges that until providers alter how they both think about and use telehealth technology everyday to deliver services to consumers, we are fighting an uphill battle. Some might say telehealth is simply providers trying to get additional money out of the federal treasury for more gadgets that only a small segment of consumers and providers will really want or use. In the area of licensure, again it is the very human and consumer-driven need to get the best care possible for one's self and family that seemed in the end to be the most persuasive marketplace and policy force that we could identify to drive these changes. The same could be said of telecommunications infrastructure development and the high cost of connectivity. Finally, the importance of developing personalized patient-provider relationships was again emphasized as a way to reduce malpractice liability, with telehealth perhaps providing new opportunities for developing such relationships, while at the same time challenging our conceptions of what this relationship entails.

With that, I'd like to thank the panel for their enthusiastic participation and thank all of you for being here. Again, I applaud the University of North Dakota Law Review for recognizing that telehealth may in fact represent the next iteration of the changing health care system, particularly for rural communities, and for inviting each of us on the panel to participate in this effort to wrestle with some of the truly novel and extremely challenging legal and regulatory issues that telehealth presents.