

**Illinois Department of Healthcare and Family Services**  
**Medicaid Advisory Committee**  
**Telemedicine Taskforce (TMT)**  
**May 9, 2018**

**TMT Members Present:**

Lt. Governor Evelyn Sanguinetti – Co-Chair  
Howard Peters – Co-Chair

Allen, Tom - Blue Cross Blue Shield  
Antoniotti, Nina - SIU Med  
Bohling, Katie - Lurie Children's Hospital  
Foster, Eric - Illinois Association of Behavioral Health  
Gallagher, Patrick - Illinois Health & Hospital Association  
Garza, Raul - Aunt Martha's  
Goyal, Arvind-HFS  
Grover, Angela - Presence Health  
Guither, Sheila - OSF HealthCare  
Hampton, Angie - Egyptian Health Department  
Harlow, Sherrie - Southern Illinois Healthcare  
Kaszak, Nancy - Illinois Telehealth Initiative  
Lindsey, Marvin - Community Behavioral Healthcare Association  
Provateare, Joe - Robert Young Center  
Sosa, Meryl - Illinois Psychiatric Society  
Valinoti, Lila - ISMS  
Winnett, Cyrus - Illinois Association of Medicaid Health Plan  
Yohanna, Daniel - University of Chicago

**HFS Staff:**

Carr, Jodi  
Cunningham, Kelly  
Easton, Cheryl  
McCullough, Kim  
Norwood, Felicia, HFS Director

**Governor's Office:** Kantas, Chris  
**Lt. Governor Staff:** Colgan, Brian

**Interested Parties:**

Carmichael, Terri – CBHA  
Cuffle, Pam – Dental Society  
Schubert, Ralph  
Stoevzer, Dana

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**Meeting Minutes**

- I. **Welcome & Introductions:** The inaugural bi-weekly meeting of the Medicaid Advisory Committee Telemedicine Taskforce was called to order on May 9, 2018, at 12:00 pm by Director Norwood who then introduced Lieutenant Governor Evelyn Sanguinetti and Howard Peters as co-chairs of the Telemedicine Taskforce, followed by introduction of Committee Members in Chicago and Springfield. Opening Comments were made by Lieutenant Governor Sanguinetti and Howard Peters.
  
- II. **Mission of Medicaid Telemedicine Taskforce:** Director Norwood stated that the Taskforce was convened to get the best ideas from across the state for ways to improve HFS' strategy for using telemedicine in the Medicaid Program in the State of Illinois. She advised the members that the primary responsibility is to the Medicaid beneficiaries for which HFS has responsibility. The Taskforce's focus is on recommendations to changes in telemedicine from a Medicaid perspective to inform the Governor and Lieutenant Governor. This is an opportunity to really shape what telemedicine and telehealth look like from a Medicaid perspective for the years to come. We want to leverage the expertise of the individuals that are engaged every day in delivering services to our beneficiaries to help us enhance and improve a program that we believe can be a best in class program for Medicaid beneficiaries in Illinois. We welcome your input. The scope is Medicaid, anything outside of that is something for others to consider. Recommendations from this Taskforce may include changes that can be made by rule, by statute or by state plan amendment.
  
- III. **National Trends in Medicaid Telemedicine Policy:** Dr. Goyal, HFS Medical Director, gave an update on national trends using a slide presentation, which is attached to these minutes, and also posted on the HFS website. US National Library of Medicine defines Telemedicine as: Use of technology to deliver healthcare at a distance. Generally accepted clinical definition of telemedicine allows health care professionals to evaluate, diagnose and treat patients in remote locations using telecommunications technology that Phone, fax machines and e mail systems are not acceptable telecommunication vehicles. Telehealth also includes professional education, public education, public health kind of things which may or may not be included as a Medicaid benefit. There are new and emerging sub-specialties within Telemedicine, as well, Examples include:
  - Telestroke, where a patient's stroke is managed remotely via Telemedicine. So in case of a stroke due to a blood clot, where time is so critical, can be monitored and tpa, a medicine to dissolve the clot can be administered remotely..
  - TelePsychiatry, which requires little physical examination of a patient, can adequately be provided remotely,
  - Similarly teledermatology, telecardiology and several other specialty services can be provided remotely with defined protocols.  
Many insurers, including Medicare, only cover real time or synchronous coverage. Remote patient monitoring is happening in some programs: a downstate/central Illinois hospital has a cardiologist on call to remotely monitors

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in ICUs and CCUs. Store and forward, or Asynchronous modality is also available, but not currently acceptable to many insurers.

**Medicare Coverage:**

- Medicare coverage requires patient to be rolled in Part B; pays 80% as usual.; is available only to patients who live in rural counties or HPSA service area outside the metropolitan statistical areas; at the time of service patient must be located in a regular or critical access hospital (CAH) hospital or CAH based Dialysis Center, a skilled nursing facility, a community mental health center, a rural health center, an FQHC, or a medical practitioner's office..
- Practitioners who provide telemedicine services must participate in Medicare and must be a physician, a nurse practitioner, a physician assistant, a nurses, a midwife, a clinical psychologist, a clinical social worker, a registered dietician, or another nutritional professional.
- Only real-time video chat with 2 way communication is covered between an eligible practitioner and patient.

**VA Coverage:**

VA operates the largest telehealth system in the world. The last number covered 50,000 veterans in 2012

- Britain's National Health Services is working to emulate that system.
- VA enrolls only patients with chronic conditions like hypertension, diabetes, congestive heart failure, PTSD etc. Patients who qualify receive free tele-monitoring equipment.
- VA provides care coordinators who teach patients self-management.
- No co-pays for most telehealth services under the VA and there is no rural residency requirement as it is for Medicare.
- In spite of VA's generous telemedicine coverage policies, wonder why they have access problems?

**Tricare Coverage:**

- Covers families of active servicemen and veterans
- The US Department of Defense sets Tricare policies which don't necessarily follow what CMS or Medicare covers.
- Telemedicine is a covered benefit
- No rural residence requirement
- No originating site restrictions.

**Private and commercial insurance coverage:**

- It is variable based on state law mandates, Coverage is increasing and there are now 36 states requiring active telehealth coverage for all insureds, not just for Medicaid recipients.
- Self-insured employer sponsored plans, which cover more than 50 percent of US workers, are exempt from such state laws.

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- Many insurers cover telehealth even without the mandate because they see value in it

**State Medicaid Programs Coverage:**

- Forty-eight states and D.C. currently pay for live video chat
- Twenty-one states pay for remote monitoring
- Fifteen states pay for store, forward, and read later option
- Thirty-two states pay originating site fee..
- Thirty states require informed consent.
- Nine states require special license or certificate to participate in the Telemedicine outcomes data (Quality Improvement, Improved Access, or Cost Savings) from each state has not yet been published

**Ethical Issues and Challenges with Telemedicine:**

- Telehealth has to comply with all applicable statutes and regulations
- Quality of care delivered via Telemedicine must equal Face to Face Care
- Proper protocol and equipment must be in place
- Each telemedicine encounter must be documented as any face to face visit.
- Informed Consent from patients and patient identification is important.
- Patient safety, confidentiality and privacy must be protected.
- Continuity of care and follow up must be assured.
- American College of Physician' policy states that Telemedicine should remain an intermittent option.
- American Medical Association's policy specifies that a valid patient-physician relationship must be established before the provision of telemedicine services.

The floor was then opened for comments and Q&A.

**IV. Illinois' Current Medicaid Telemedicine Landscape:** Kelly Cunningham gave an update on Illinois' Current Medicaid Telemedicine Landscape.

- The original telemedicine legislation impacting the Illinois Medicaid Program was enacted in 2007; over 10 years ago. The delivery of services through telemedicine technology is certainly not new to our Medicaid Program. Aside from some reimbursement changes associated with the SMART Act in 2012, the first major change in the telemedicine statute did not occur until August of 2017. The statute was amended to remove the requirement that a physician or other licensed healthcare professional be present with the patient at all times at the originating site and only be present at the originating site.
- Telepsychiatry services can currently be billed (as the distant site provider) by physicians licensed by the State of Illinois (or by the state where the patient is located) who have completed an accredited general psychiatry residency program or accredited child and adolescent psychiatry residency program. Telemedicine services can be billed (as the distant site provider) by a physician,

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physician assistant, podiatrist or advanced practice nurse licensed by the State of Illinois or by the state where the patient is located.

- Administrative rules governing the provision of services through telemedicine technology in the Illinois Medicaid program can be found at 89 Illinois Administrative Code 140.403. Major components of the rule cover the provider types allowed to bill for services as distant site providers; reimbursement methodology for the originating and distant site provider, as well as encounter clinic; and record requirements for services.

The floor was then opened for comments and Q&A

V. **Pending Legislation:** Postponed.

VI. **Miscellaneous:** Suggestions and comments should be submitted directly to Kimberly McCullough-Starks at [Kim.McCullough@illinois.gov](mailto:Kim.McCullough@illinois.gov).

VII. **Next Steps & Adjournment: The Chair announced:** We want to make sure that the group can get back together again so that we can act with a sense of getting some things done and accomplished; get everybody back around the table so we can try to figure out in terms of our next meeting. If we can get everybody the documents that we referenced today and give people the opportunity to look them over; we can come back with some specific next steps. We are looking at meeting every other week as opposed to every week in terms of a meeting schedule perspective.

Meeting was adjourned at 12:26 p.m.

**Next meeting is scheduled for: May 23, 2018.**