



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

June 16, 2014

The Honorable Joe Pitts, Chairman
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

The Honorable Frank Pallone, Ranking Member
Subcommittee on Health
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

RE: Call for Proposals on Telemedicine

Dear Chairman Pitts and Ranking Member Pallone:

On behalf of the 115,900 physician and student members of the American Academy of Family Physicians (AAFP), thank you for the opportunity to submit proposals on telemedicine. The AAFP applauds you for your bipartisan leadership on this topic, noting that Congress enacted the current telemedicine framework in Medicare in December 2000—well before the advent of smart-phones, tablets, and many other now-ubiquitous technology tools that physicians and their patients can use to improve both the quality of health care and the patient experience. Therefore the AAFP appreciates your invitation to comment on this timely effort to update American telemedicine policy.

The AAFP's policy on telemedicine is stated simply: payment for physician services should be made provided that the services are (1) reasonable and necessary, (2) safe and effective, (3) medically appropriate, and (4) provided in accordance with accepted standards of medical practice. The AAFP believes that the technology used to deliver the service should not be the primary consideration driving reimbursement; rather, the critical test is simply whether the service is medically reasonable and necessary.

With that guiding principle, the AAFP respectfully submits the following proposals:

1. Facility Fee for an Originating Site Should Cover a Physician Practice's Associated Costs

A family physician's office can qualify as an originating site under current law. And family practices are ideally suited to act as originating sites in their role as primary care physicians helping to facilitate the delivery of services from other providers who are off-site (e.g. a social worker, nutritionist, or other physician). However, a family practice that invests in the physical space and reliable *Health Insurance Portability and Accountability Act* or "HIPAA"-compliant equipment for patients to receive services from providers off-site should also receive payment to cover the associated fixed and variable costs. In

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CY2014, this facility fee is \$24.63.¹ While other originating sites (particularly hospitals and other institutional providers) may benefit from revenue bases and economies of scale that permit this investment, the AAFP does not believe that this fee is reasonably calculated to cover such costs in the case of the physician's office. Accordingly, the AAFP urges the Subcommittee in any bill that it develops to reassess this payment to ensure that it appropriately incentivizes primary care practices to participate as originating sites (as they are currently defined).

2. "Telehealth Services" Should be Defined Broadly

Current law generally limits "telehealth services" to professional consultations, office visits, and office psychiatry services, furnished via a telecommunications system. CMS defines such telecommunications systems as "multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician."² CMS further explicitly states: "Telephones, facsimile machines, and electronic email systems do not meet the definition of an interactive telecommunications system."³

The AAFP views telemedicine and telehealth services much more broadly. The AAFP considers telemedicine to encompass a range of processes and services intended to enrich the delivery of medical care and improve the health status of patients—not only virtual office visits, but also transmission of diagnostic images or video that a specialist reviews later (store-and-forward technologies that provide for the asynchronous transmission of health-care information), and remote patient monitoring. The AAFP also believes that telemedicine includes simpler methods of delivering health care such as an email or phone call. Relying on their training and experience, as well as their knowledge of their patients' needs, family physicians are ideally situated to employ a range of technological modalities to enrich the delivery of primary care, on a case-by-case basis. In recognition of this, the AAFP encourages the Subcommittee to define telemedicine and telehealth as broadly as reasonably possible.

3. "Originating Site" Should be Defined Broadly

Current law requires that an eligible telehealth individual (i.e. the patient) be a Medicare beneficiary who receives a telehealth service furnished at an originating site. There are two requirements for the originating site: first, the site must be one of eight enumerated providers;⁴ and second, the site must be located in a rural health professional shortage area, or in a county that is not included in a Metropolitan Statistical Area. The AAFP would advocate for the removal of these restrictions on originating site.

First, many AAFP members deliver care to their patients in the home via telephone, email, videoconferencing, and other means, based on a sense of professional obligation and a desire to provide excellent care. But Medicare and most payers do not reimburse physicians for these services

¹ See Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule, Clinical Laboratory Fee Schedule & Other Revisions to Part B for CY 2014, 78 Fed. Reg. 74,230, at 74,405 (Dec. 10, 2013) ("CY2014 Final Rule").

² 42 C.F.R. § 410.78(a)(3).

³ *Id.*

⁴ Defined under Section 1834(m)(4)(C)(ii) of the Social Security Act as: (1) the office of a physician or practitioner, (2) a critical access hospital, (3) a rural health clinic, (4) a federally qualified health center, (5) a hospital, (6) a hospital-based or critical access hospital-based renal dialysis center, (7) a skilled nursing facility, or (8) a community mental health center.

since the patient's home does not qualify as an originating site. Thus, the AAFP urges the Subcommittee to incentivize physicians to deliver the right care, in the right place, at the right time which in many cases includes consulting with patients who may not be able to leave the house.

Second, in the intervening 14 years since Congress drafted and enacted current law the use of communications technology in the workplace has grown geometrically. On a near-constant basis, not just clinical professionals but all types of American professionals now rely on email, teleconferencing, videoconferencing, and other tools to conduct business and serve clients regardless of whether they are based in a rural or urban setting. Many industries use email as a communication tool and meeting substitute even within their own office building. Acknowledging the continuing need for telemedicine for patients who live in rural and remote areas, the AAFP urges the Subcommittee to remove this somewhat antiquated requirement that only rural-based patients can qualify for telemedicine services. In short, removing the site and place restrictions will greatly enhance the free flow of health services based on patient need.

4. Licensure Should Remain a Matter Principally of State Regulation

Finally, the AAFP acknowledges and appreciates the leadership of several Subcommittee members in proposing to remove obstacles to delivering telemedicine across state lines posed by state licensure (for example in HR 3077, *The TELE-MED Act of 2013*). The AAFP, however, opposes the concept of licensure on the federal level.⁵ To facilitate delivery of care across state lines, the AAFP encourages states to engage in reciprocity compacts for physician licensing, especially to permit the use of telemedicine. Accordingly, and because the Federation of State Medical Boards is currently developing an Interstate Medical Licensure Compact, under which physicians would be eligible for expedited licensure in all participating states, the AAFP urges the Subcommittee and Congress not to regulate medical licensure.

5. The Principles Outlined Above Apply to Medicaid and CHIP

The AAFP notes that currently telemedicine is not a distinct service under Medicaid, but varies based on each state's Medicaid program. To the extent that the Subcommittee also seeks to establish uniform federal standards in Medicaid and CHIP, the AAFP re-asserts the principles outlined above as applying to those programs as well.

Thank you once again for your leadership on telemedicine and for the opportunity to submit this feedback. If you would like to follow up with the AAFP, please do not hesitate to have your staff contact Andrew Adair, Government Relations Representative, at (202) 232-9033 or aadair@aafp.org.

Sincerely,



Jeffrey J. Cain, MD, FAAFP
Board Chair

⁵ In the limited case of existing patients (where the doctor-patient relationship has been established through a face-to-face visit), the AAFP does believe that policies should be established that allow a physician to provide care, via telehealth, in states where they may not have a license.

Appendix:
AAFP Policies Related to Telemedicine

1. Telemedicine

Telemedicine is the use of medical information that is exchanged from one site to another through electronic communications. It includes varying types of processes and services intended to enrich the delivery of medical care and improve the health status of patients.

Some of these processes and services include:

- Subspecialists' consultations and may involve the patient "seeing" the subspecialist during a live, remote consult. It may also include the transmission of diagnostic images or video that the specialist reviews later.
- Using electronic communications that collect and send information to foster remote patient monitoring, such as vital signs or blood glucose levels. Monitoring of this nature assists homebound patients or care coordination between providers.

"Closely associated with Telemedicine is the term 'telehealth' which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services.

Videoconferencing, transmission of still images, e-health including patient portals, nurse call centers, and remotely tracking vitals are all considered part of telemedicine or telehealth." (incorporating the American Telemedicine Association's definition of Telehealth).¹

(available at <http://www.aafp.org/about/policies/all/telemedicine.html>)

2. Telemedicine, Licensure and Payment

The delivery of healthcare services via telemedicine should be consistent with the principles of ethical medical practice. Regulation should not unduly restrict accessibility of telemedicine services, but appropriate licensure should be assured to protect the patient and the referring physician. The AAFP opposes the creation of unreasonable barriers to the practice of telemedicine across borders by state licensing boards; however, full legal accountability for the ordering and interpreting of telemedicine

¹ See American Telemedicine Association, "For the Media," available at <http://www.americantelemed.org/news/for-the-media#.U2D6fPldXT0>

services must be maintained. Family physicians should have full discretion in selecting the most appropriate consultants for their patients.

By creating ready access to information, telemedicine can provide physicians with current medical information that may not otherwise be available in a given setting. The AAFP believes that payment should be made for physician services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the service should not be the primary consideration; the critical test is whether the service is medically reasonable and necessary. Care provided via telemedicine should be paid as other physician services. A record of telemedicine interactions must be created that becomes part of the patient's medical record.

(available at <http://www.aafp.org/about/policies/all/telemedicine-licensure.html>)

3. Licensure

The AAFP supports the concept of licensure and relicensure at the state level, as presently provided, and opposes the concept of such licensure on a federal level. The AAFP encourages states to engage in reciprocity compacts for physician licensing, especially to permit the use of telemedicine.

(available at <http://www.aafp.org/about/policies/all/licensure.html>)