



AMERICAN ACADEMY OF
FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

May 9, 2014

Hon. Mike Thompson
231 Cannon House Office Building
Washington, D.C. 20515

RE: Telehealth Promotion Act of 2014

Dear Rep. Thompson:

On behalf of the 110,600 physician and student members of the American Academy of Family Physicians (AAFP), thank you for the opportunity to submit public comments on the “*Telehealth Promotion Act of 2014*” discussion draft. You have encouraged commenters to “include questions or comments regarding state licensure, credentialing/accreditation of providers, infrastructure, physician liability, consumer protection, telehealth reimbursement policies, physician use of curbside consultations, or other pertinent issues you think should be taken into consideration.” The AAFP’s comments are set forth below.

SUMMARY OF AAFP POSITION

Under current payment frameworks, AAFP members who provide telehealth services to their patients most often do so in their role as primary physician and care coordinator—for example, helping coordinate live remote consults between their patients and another professional (e.g., a social worker, nutritionist, or another physician) while the patient is in the family physician’s office. As such, the AAFP supports policies that more broadly encourage the delivery of telehealth, allowing family physicians to more easily and readily connect their patients to such consultations and other services through a telecommunications device. Wider adoption and use of a broad array of telehealth services will allow family physicians to oversee and manage the patient’s care, rather than relying on the practice of referring patients to other services and then waiting for follow-up information.

In addition, many AAFP members welcome the opportunity to furnish telehealth services to their patients, and would do so now except that government and private insurers generally will not reimburse family physicians for furnishing these services (e.g., Medicare Part B will not reimburse a physician who provides a consultation to a patient at home via a telecommunications device, because a patient’s home does not qualify as an “originating site” under Medicare Part B).

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Accordingly, the AAFP welcomes the draft bill to the extent that it would remove certain major barriers to payment for telehealth services. The AAFP supports lifting geographic restrictions on the Medicare definition of originating site, as well as providing authority to CMS to expand delivery of telehealth beyond the statutorily defined list of such originating sites. The AAFP also favors broadening the term “telecommunications device” to include store-and-forward technologies. The AAFP views with caution, however, policies that would expand the list of billable telehealth services beyond current policy, and opposes policies that allow an undefined category of “other healthcare professional” to be an eligible distant-site practitioner. Finally, the AAFP generally opposes policies that allow for providers to furnish services to patients in other states where the provider is not formally recognized by that jurisdiction with a license to practice—except in the limited case of physicians providing services to established patients.

DISCUSSION

1. The AAFP Supports a Meaningful Facility Fee for the Originating Site.

Preliminarily, although the discussion draft does not address this issue, it must be noted that a family physician coordinating care does not receive a fee for telemedicine services under Part B; rather, the family practice acting as an originating site receives a facility fee, which during CY2014 is \$24.63.¹ (The fee was set in statute at \$20 and is adjusted for inflation annually.) Without increasing this payment to cover the fixed and variable costs of being an originating site, there will be little incentive aside from professional responsibility driving AAFP members to connect their patients to telehealth services. Thus, the AAFP urges you in any bill you introduce to reassess this payment and adjust it to better reflect such costs.

2. The AAFP Supports More “Neutrality” Between Telehealth and Face-to-Face Services.

The heart of the bill is the “neutrality” language in Section 2(a) and Section 3, which would place telehealth services (services furnished via a telecommunications system) on equal footing with covered face-to-face services in the Medicare (Parts A and B), Medicaid, Children’s Health Insurance Program (CHIP), and the Federal Employees Health Benefits Program (FEHBP). This language would allow distant-site practitioners to be paid for any covered service performed via a telecommunications system as if the service were performed face-to-face.

In general, this neutrality language is consistent with AAFP policy, which provides:

[P]ayment 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

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”).

the service is medically reasonable and necessary. Care provided via telemedicine should be paid as other physician services.²

Thus, the AAFP supports payment parity between telehealth services and face-to-face services, but with some caveats, outlined below.

3. The AAFP Supports Removal of the Following Barriers in Medicare Part B:

- Removing Geographic Limitations on Part B Originating Site

Under Medicare Part B, telehealth services can be furnished only in a qualifying originating site. Section 2(b)(4) of the draft removes the requirements that an originating site be either (1) in a Health Professional Shortage Area (HPSA), (2) a county that is not included in a Metropolitan Statistical Area, or (3) part of a participating telemedicine demonstration project. The AAFP recognizes the special need for telehealth services that patients in rural and remote areas may have. At the same time, AAFP policy on payment for non-face-to-face physician services favors payment for all physician services that are medically reasonable and necessary, and thus supports lifting these restrictions.

- Providing CMS with Authority to Pay for Services for Eligible Telehealth Beneficiaries Not in a Qualifying Originating Site

Under Section 2(b)(6) of the draft, CMS “may develop and implement payment methods that would apply . . . except that the telehealth services are furnished [to] the individual at a site other than an originating site.” Family physicians are eager for CMS and other payers to more fully recognize the value of non face-to-face care management. In this vein, CMS is creating a new code for chronic-care management (CCM) services. At the same time, many AAFP members would also avail themselves of opportunities to make remote “house calls” while patients are at home, which may not be captured by the CCM code. The AAFP, therefore, supports granting this new authority to CMS.

- Expanding Scope of Telehealth to Include Store-and-Forward Technologies

Section 2(b)(2) of the draft would expand the definition of “telecommunications system” under Part B to include “store-and-forward technologies that provide for the asynchronous transmission of health care information in single or multimedia formats.” The AAFP supports a broad definition of telehealth services that includes not just remote consultations but a range of processes and services “intended to enrich the delivery of medical care and improve the health status of patients,”³ including but not limited to store-and-forward technologies. In addition, AAFP policy expressly includes “the transmission of diagnostic images or video that the specialist reviews later” as a component of its definition of telemedicine.⁴

² AAFP, “Telemedicine, Licensure, and Payment,” *available at* <http://www.aafp.org/about/policies/all/telemedicine-licensure.html>; *see also* AAFP, “Payment for Non Face-to-Face Physician Services,” *available at* <http://www.aafp.org/about/policies/all/payment-services.html>

³ AAFP, “Telemedicine,” *available at* <http://www.aafp.org/about/policies/all/telemedicine.html>

⁴ *Id.*

4. The AAFP Views with Caution Broadening the Scope of Covered Services Beyond Current Law

Section 2(b)(1) of the draft would delete the definition of “telehealth service” which currently limits such services to a statutorily defined set of common procedural terminology (CPT) codes (covering professional consultations, office visits, and office psychiatry services), as well as “any additional service specified by the Secretary,” thereby removing all restrictions on the term. Section 2(b)(7) then limits telehealth services to those services “for which payment would be made under the fee schedule under section 1848 if furnished in the same location as the beneficiary;” i.e., all Medicare physician services. The AAFP questions whether these revisions are prudent or necessary.

Part B currently covers 21 telehealth services that cover a wide range of patient needs.⁵ The scope of billable services does not generally present an obstacle to family physicians who wish to connect their patients to services via telehealth. In addition, aside from the impossibility of performing certain services remotely (surgical, physical therapy, and any other hands-on service), CMS already has the authority to add services.

5. The AAFP Opposes Expanding Distant-Site Practitioner to Include “Other Health Care Professional.”

Section 2(b)(3) would expand the scope of distant-site practitioners to include “other health care professional” which is an undefined term in the discussion draft. Although family physicians coordinate care with a wide variety of other physicians and non-physicians, the AAFP sees no compelling reason to expand this category beyond “physician” and “practitioner” as defined in Medicare. CMS currently includes as distant-site practitioners: physicians, physician assistants (PAs), nurse practitioners (NPs), clinical nurse specialist (CNS), nurse-midwives, clinical psychologists, clinical social workers, and registered dietitians and nutrition professionals⁶—collectively representing all of the principal roles of a high-functioning primary-care team. Without a strong rationale for expanding this set of practitioners, and without language in the bill to ensure only those professionals who belong to a recognized health profession and are licensed to practice qualify, the AAFP opposes an expansion of this category.

⁵ Medicare Part B reimburses distant-site practitioners for (1) initial inpatient consultations; (2) follow-up inpatient consultations; (3) office or other outpatient visits; (4) individual psychotherapy; (5) pharmacologic management; (6) psychiatric diagnostic interview examination; (7) end-stage renal disease (ESRD) related services; (8) individual and group medical nutrition therapy (MNT); (9) neurobehavioral status exam; (10) individual and group health and behavior assessment and intervention (HBAI); (11) subsequent hospital care; (12) subsequent nursing facility care; (13) individual and group kidney disease education (KDE); (14) individual and group diabetes self-management training (DSMT); (15) smoking cessation services; (16) alcohol and/or substance abuse and brief intervention services; (17) screening and behavioral counseling interventions in primary care to reduce alcohol misuse; (18) screening for depression in adults; (19) screening for sexually transmitted infections (STIs) and high intensity behavioral counseling (HIBC) to prevent STIs; (20) intensive behavioral therapy for cardiovascular disease; and (21) behavioral counseling for obesity. See CY2014 Final Rule, 78 Fed. Reg. 74,230, at 74,399.

⁶ CY2014 Final Rule, 78 Fed. Reg. at 74,400.

6. The AAFP Does Not Support National Licensure to Allow Physician Services to Flow across State Lines.

The bill provides that for Medicare Part B, Medicaid, CHIP, and FEHBP, “For the purposes of reimbursement, licensure, professional liability, and other purposes, providers of such services are considered to be furnishing such services at their location and not at the originating site.”⁷ Although setting the location of the service at the place of the furnishing practitioner (the distant site) may result in more ease in administration, the AAFP views the place of a physician service as the place where the patient receives the care.

- Licensure

Despite AAFP policy supporting wider adoption and use of telehealth services, AAFP policy also provides that “appropriate licensure should be assured to protect patient and referring physician.”⁸ The AAFP “supports the concept of licensure and re-licensure 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.”⁹ Although the draft does not establish a federal license for the practice of medicine, this language purports to allow a physician licensed in a single jurisdiction to provide care to patients in jurisdictions in which the physician is not licensed to practice. Even assuming that this bill would have the legal effect of preempting well-developed bodies of state law that currently regulate medical practice (a question for the federal courts and by no means a certain outcome), the bill would strip the states of their traditional role of regulating professional practice within their own borders, including disciplining those who violate rules of professional responsibility. However, in the limited case of existing patients (where the doctor-patient relationship has been established through a face-to-face visit), we do believe that policies should be established that allow a physician to provide care, via telehealth, in states where they may not have a license.

- Reimbursement

Medicare Part B is a national open-access program where the physician can receive payment for services rendered to any beneficiary. Therefore, aside from minor variations in payment amount based on geography, there is no discernible advantage to physicians or their patients in making the physician’s location the place of service. So too with FEHBP, which operates through private insurers and therefore reimburses only those providers within a network. Shifting the place of service to the location of the physician should have no discernible impact.

There is also likely little advantage for Medicaid and CHIP reimbursement. First, it seems highly unlikely that a state Medicaid program would agree to pay a distant-site professional for services furnished to a patient residing in another state who is not enrolled in that Medicaid program. Therefore, the distant-site professional would have to either participate as a provider in the Medicaid program in which the patient is enrolled, or else receive payment through a contract under which a state Medicaid program pays out-of-state professionals to furnish

⁷ The AAFP presumes that no similar language was applied to Part A because such services (hospital, skilled nursing, home health, and so forth) cannot be provided remotely.

⁸ AAFP, “Telemedicine, Licensure, and Payment.”

⁹ AAFP, “Licensure,” available at <http://www.aafp.org/about/policies/all/licensure.html>.

telehealth services. In either case denoting the distant-site professional's place of business as the place where the service occurs is probably not helpful for purposes of Medicaid or CHIP reimbursement.

- Medical Liability

Standards of care in negligence vary from state to state. Defining the place of service to the place of the distant-site professional would likely insulate that practitioner from some claims for negligent conduct, since the provider would not be exposed to the law of the place where care is received. However, the family physician coordinating the care at an originating site may be at greater risk of professional liability if the distant-site professional engages in conduct defined as negligent in the jurisdiction where the care is received. A patient with a valid claim under the law of the state in which the care is received may then look to the family physician for recovery rather than to the furnishing professional. In short, at the margins this rule could potentially protect the distant-site professional, and shift risk of loss to the family physician and the patient.

Thank you once again for your leadership and for the opportunity to comment on the draft proposal. 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,

A handwritten signature in black ink, appearing to be 'J. Cain', with a long horizontal flourish extending to the right.

Jeffrey J. Cain, MD, FAAFP
Board Chair