



National Advisory Committee On Rural Health and Human Services



Telehealth in Rural America Policy Brief March 2015

Editorial Note: During its Fall 2014 meeting in Sioux Falls, South Dakota, the National Advisory Committee on Rural Health and Human Services discussed the use of telehealth in rural areas and how this technology aligns with the emerging focus on value in health care. The Committee met with rural health research experts, health care providers, and patients. The Health Subcommittees held meetings with stakeholders at the Pipestone County Medical Center and Family Clinic Avera and at the Good Samaritan Society – Pipestone, both in Pipestone, Minnesota, and with stakeholders at the Howard Community Health Center in Howard, South Dakota. There they learned about the utilization of telehealth services in a Critical Access Hospital, a long term care facility, and a Federally-Qualified Health Center. This policy brief continues the Committee’s examination of the rural American health care system under the ACA and offers recommendations to the Secretary of the U.S. Department of Health and Human Services (HHS) for improving access to health care through telehealth in a value-focused future.

RECOMMENDATIONS

1. The Committee recommends that the Secretary seek a change in legislation to allow Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to serve as eligible distant sites (see page 6).
2. The Committee recommends that the Secretary revise the regulations that allow one telehealth visit for patients in nursing facilities from one encounter every 30 days to as many visits as clinically necessary but also medically appropriate for managing unanticipated acute situations. (see page 6).
3. The Committee recommends that the Secretary seek a change in legislation allowing home health certification and re-certification to take place via telehealth equipment within patients’ homes for rural beneficiaries in qualifying telehealth areas (see page 7).
4. The Committee reiterates its recommendation in its August 2013 brief on the Medicare Hospice Benefit that the Secretary seek a change in legislation allowing telehealth consultations to count as face-to-face encounters to certify and re-certify the need for hospice care, as proposed in a previous Committee policy brief (see page 7 and previous brief).
5. The Committee recommends that the Secretary direct Centers for Medicare & Medicaid Services (CMS) and other HHS agencies to create standardized rural-relevant reporting metrics for telehealth (see page 7).
6. The Committee recommends that the Secretary direct the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and/or other HHS agencies to conduct more evidence-based research on telehealth effectiveness, quality, and outcomes in rural areas (see page 8).
7. The Committee recommends that the Secretary extend to all Medicare Shared Savings Program (MSSP) Accountable Care Organizations (ACOs) the waiver of the telehealth regulations as proposed under the MSSP Accountable Care Organization proposed rule. (see page 8).

INTRODUCTION

The Affordable Care Act (ACA) includes a number of health care goals: increasing the number of insured, improving quality and outcomes, reducing costs, and testing new approaches for how to reimburse providers and deliver health care services. Telehealth is mentioned only a handful of times in the ACA, and its general use within the health care system is not explicitly expanded as a result of the legislation. However, telehealth technology could play a role in helping rural communities realize the broader goals of the ACA. Now, the question for both the U.S. Department of Health and Human Services (HHS) and rural communities is how to effectively leverage telehealth to meet those goals. Telehealth has long been seen as a tool to increase access to care for isolated rural residents. HHS and other federal departments have been supporting telehealth projects for more than 25 years. In rural areas, where long distances and provider shortages are barriers to care, telehealth services increase patient access to services such as emergency department care, home health, specialty care, medication adherence, and intensive care monitoring.^{2,3}

HRSA Definition of Telehealth
<p>The Health Resources and Services Administration (HRSA) defines telehealth as the use of electronic communication and information technologies to provide or support long-distance clinical health care, patient and professional health-related education, public health, and health administration.¹</p>

Telehealth Formats

Interactive Telecommunications	Asynchronous store and forward
<p>Audio and video equipment permitting two-way, real-time interactive communication between a patient and distance site physician or practitioner.⁴</p>	<p>Transmission of a patient’s medical information from an originating site to a physician or practitioner at the distant site.⁵</p>

Telehealth is increasingly becoming an important part of a U.S. medical system that focuses more on quality and integration of care, a system that includes highly-integrated care models such as patient-centered medical homes (PCMHs) and accountable care organizations (ACOs). The Committee believes telehealth has the potential to be an important tool in health care delivery system reform and believes the technology can help rural areas take advantage of the

¹ “Telehealth.” HRSA Rural Health Glossary. Accessed November 17, 2014.

<http://www.hrsa.gov/ruralhealth/about/telehealth/glossary.html>

² For a summary of the eEmergency programs funded by the Leona M. and Harry B. Helmsley trust in 7 states, along with an overview of continuing challenges to telehealth systems, see Shelley Stingley and Heidi Schultz. “Helmsley Trust Support for Telehealth Improves Access to Care in Rural and Frontier Areas.” *Health Affairs* 33, no.2 (2014):336-341.

³ Kvedar, J., M. J. Coye, and W. Everett. “Connected Health: A Review of Technologies and Strategies to Improve Patient Care with Telemedicine and Telehealth.” *Health Aff (Millwood)* 33.2 (2014): 194-9.

⁴ 42 CFR § 410.78 (a)(3) 2011.

⁵ 42 CFR § 410.78 (a)(1) 2011.

ACA's focus on improving access to care, enhancing quality, and reducing costs. It may be that telehealth fits better in a health care system focused on value, rather than one focused on volume. Therefore, the September 2014 meeting of the National Advisory Committee on Rural Health and Human Services (the Committee) focused on key policy issues facing rural communities in utilizing telehealth technology to improve access and outcomes while emphasizing value. How can telehealth add to value and improve quality in the rural health care system?

BACKGROUND

Telehealth Reimbursement

Medicare payment for telehealth services is established in Section 1834(m) of the Social Security Act.⁶ These services are covered under the Medicare Fee-For-Service Program, and a limited number of services are reimbursed.⁷ The Social Security Act includes several important specifications for telehealth care, including who is considered a qualified physician or practitioner⁸ and the approved types of originating sites.⁹ Medicare reimbursement for telehealth services is conditional on the originating site being located in a non-metro county or in a primary care or mental health geographic Health Professional Shortage Area located in a rural Census Tract of a metropolitan county.¹⁰ It is important to note that Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) - both of which are major elements of the rural safety net - are eligible originating sites, but they are not reimbursed as distant site physician or practitioners because they submit claims to Medicare as facilities, not as individual providers. The Committee is concerned that the current list of covered services and facilities excludes some key rural safety net providers.

Though the federal statute for Medicaid does not include telehealth as a distinct service, Medicaid reimbursement for telehealth is provided in some form by 46 states and the District of Columbia.^{11,12,13} States can choose whether or not telehealth services are covered, what services are covered in what geographic areas, which practitioners are reimbursed, and how much services are reimbursed, as long as the states ensure access to care and follow Medicaid and other federal laws and regulations.

Currently, 21 states and the District of Columbia require telehealth coverage by private health

⁶ Social Security Act, Title 18, Section 1834.

⁷ "Telehealth Services." Rural Health Fact Sheet Series. Centers for Medicare and Medicaid Services. (2013): 1.

⁸ Social Security Act, Title 18, Section 1861(r). Accessed September 2, 2014.

⁹ "Telehealth Services," 2.

¹⁰ "Telehealth Services," 1.

¹¹ "Telemedicine." Medicaid website. Accessed September 2, 2014. <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html>

¹² "State Coverage for Telehealth Services." National Conference of State Legislatures. Web. Accessed September 3, 2014. <http://www.ncsl.org/research/health/state-coverage-for-telehealth-services.aspx>

¹³ "State Telehealth Policies and Reimbursement Schedules: A Comprehensive Plan of the 50 States and District of Columbia." Center for Connected Health Policy, The National Telehealth Policy Resource Center. September 2014. Accessed September 3, 2014.

<http://cchpca.org/sites/default/files/uploader/50%20STATE%20MEDICAID%20REPORT%20SEPT%202014.pdf>

insurance plans.¹⁴ Aetna, WellPoint, Highmark, Cigna, and other large insurance companies appear to cover telehealth in some way.¹⁵

Advocates often cite concerns about reimbursement for telehealth services. While Medicare has paid for telehealth services since 1997, utilization has remained moderate, and there is little data about other payers such as Medicaid or private insurance.¹⁶ The Veterans Administration (VA) relies more heavily on telehealth, but as a closed system, it has not seen these challenges in reimbursement.

Telehealth in Practice

Benefits

Telehealth is helping to improve the rural health care system in many ways, and some of these ways were illustrated during the Committee’s site visits. For example, the ability to access a provider remotely improves access to care for patients who would have to travel long distances to receive the same care. It also brings care to those patients who would forego care because of inconvenient and difficult travel distances and to patients without adequate transportation resources. Additionally, utilizing telehealth technologies for appointments that do not require in-person visits can save money for patients and, in some settings, for Medicaid and Medicare, when travel is reduced or eliminated. Telehealth can also improve access by recruiting and retaining more providers in rural areas, as a virtual network of professional peers can reduce rural practitioner isolation and burnout. When the quality of care provided by telehealth is equivalent to the services that would be rendered at distant locations, cost and burden are reduced for patients, family members, and insurance providers.

Telehealth can also have impacts in a long-term care setting. As explained at the Good Samaritan Society visit, telehealth can

Avera’s Health Care Innovation Award

In 2014, Avera Health received an \$8.8 million grant as part of the Health Care Innovation Awards from the CMS Innovation Center. Funding was awarded applicants who plan to “implement the most compelling new ideas to deliver better health, improved care and lower costs...” Operating in South Dakota, Minnesota, Nebraska, and Iowa, the Avera project will focus on geriatric care services in long term care.

Using standardized tools and processes, the Avera eHelm will lend its expertise to more than 30 long term care facilities. The goals of the project include building assessment capability and toolkits of the care team, providing long term care facility residents with access to appropriate care, and improving the management of care transitions. Avera will implement Version 2 of the Interventions to Reduce Acute Care Transfers (INTERACT II) at facilities to improve care and reduce costs for the vulnerable elderly population.

¹⁴ “2014 State Telemedicine Legislation Tracking.” American Telemedicine Association. Last updated August 14, 2014. Accessed September 3, 2014. <http://www.americantelemed.org/docs/default-source/policy/state-telemedicine-policy-matrix.pdf?sfvrsn=14>

¹⁵ Anderson, C. “Private Payers Are Advancing the Use of Telemedicine Technology.” *Healthcare IT News* (2013). Web. Accessed September 4, 2014. <http://www.healthcareitnews.com/news/private-payers-are-advancing-use-telemedicine-technology>

¹⁶ Gilman, M., and J. Stensland. “Telehealth and Medicare: Payment Policy, Current Use, and Prospects for Growth.” *Medicare Medicaid Res Rev* 3.4 (2013).

simultaneously lead to an efficient use of resources and a reduction in hospital re-admissions. For example, telehealth allows remote access to physicians at all hours, and doctors can give some orders without a patient having to travel to a hospital. When these orders can be taken care of by nurses and other local staff, staff can maintain and use more of their skills and knowledge to aid patients who would otherwise be sent to a hospital, usually via ambulance. This can lead to improved care and lower costs for the patient, with less inconvenience.

Areas of Concern

In the text of the ACA, telehealth is mentioned only a few times. Many of these sections involve redefining “face-to-face” encounters to include telehealth visits. Telehealth is further included in sections about testing models of health care and ACOs. Given this finite inclusion in the ACA, there are limitations on how telehealth can be used to achieve the legislation’s objectives.

Of more immediate concern are physicians who may treat patients without having a previously established relationship, as can be the case with telemedicine companies that provide direct-to-consumer care. Telehealth is a promising medical practice, with the potential to increase access to quality care as patients need it. While these developments have the potential to enhance access, the Committee is concerned that direct-to-consumer services may also lead to fragmentation and the disruption of normal patterns of care if they are not well coordinated with usual sources of care. The Committee envisions telehealth as part of an interoperable continuum of care with records and treatment history, not as episodic direct-to-consumer systems. The Committee further believes that telehealth fits best when it is part of a larger system of coordinated care such as a PCMH or an ACO.

DISCUSSION AND RECOMMENDATIONS

Telehealth has the potential to improve the quality of and access to health care in rural America. As the nation’s health care system is being redesigned, new payment and delivery options are being utilized, and innovation is encouraged. The potential benefits of telehealth are documented and real-life: improving emergency care, mental health care, stroke care, and long term care; extending and supporting rural medical staffs; creating virtual support groups for both providers and patients. Barriers still remain, however, for leveraging the full value of this technology, both within the current fee-for-service system and as new payment and service delivery models emerge. If these policy concerns can be addressed, telehealth can better implement the goals at the core of the ACA: improved access, enhanced quality, continuity of care, better outcomes, and reduced growth in costs.

The Committee believes that the Centers for Medicare & Medicaid Services (CMS) could revise a number of current regulatory provisions to allow providers to take advantage of available technology and achieve the goals of the ACA.

Distant Site Provider Status

CMS interprets Section 1834(m) of the Social Security Act to prohibit FQHCs and RHCs from serving as distant site providers under Medicare. RHCs and FQHCs bill Medicare under a facility National Provider Identifier (NPI) rather than an individual physician or practitioner’s NPI. In addition, RHCs and FQHCs are prohibited from commingling – that is, operating an

RHC or FQHC simultaneously with a Part B fee schedule practice in the same space with the same physicians or practitioners. This means that space, staff, supplies, equipment, and resources cannot be shared. The Committee contends that, though RHCs and FQHCs bill as facilities and not as individual providers, individual physicians and practitioners provide the care to patients within these facilities. The Committee considers this interpretation an unnecessary limitation on the advancement of telehealth and access to health care services in rural America. RHCs and FQHCs are essential parts of the rural health safety net, and they provide care to nearly three million Medicare beneficiaries each year.¹⁷ **The Committee recommends** that the Secretary seek a change in legislation to allow RHCs and FQHCs to serve as eligible distant sites.

Nursing Facility Visits

Another area where Medicare telehealth reimbursement restrictions inhibit access to care is in nursing facility visits by providers. After the initial intake, telehealth reimbursement in nursing facilities is limited to one visit every 30 days. However, given the health of many patients in nursing facilities, more than one visit per month may be necessary due to falls, urinary tract infections, and other ailments. Without telehealth, either patients must be transported to appointments or physicians must travel to these facilities, often by ambulance transport. Not only is ambulance transportation expensive, but it is disruptive and potentially dangerous for the frail elderly. Alternately, requiring physicians and other practitioners to travel to nursing facilities to see a patient can be time consuming and inefficient with many hours spent on travel rather than patient care, particularly in light of the fact that many rural areas experience shortages of health professionals. CMS has previously recognized the burden on physicians of unnecessarily restrictive regulations and the utility of telehealth to overcome them.¹⁸ Allowing more frequent

telehealth services in nursing facilities, as necessary, would be an opportunity to improve patient care and reduce cost. To reduce these impediments to access, **the Committee recommends that** the Secretary revise the regulations that allow one telehealth visit for patients in nursing facilities from one encounter every 30 days to as many visits as clinically necessary but also medically appropriate for managing unanticipated acute situations.

Additionally, home health services reimbursed by CMS require physician certification that a patient is confined to the home and meets additional criteria for home health care. This currently requires a face-to-face visit by a physician or a

Patient Experiences: Angela

Joining the Committee on the community panels in Pipestone, MN, and Howard, SD, were patients who had directly experienced telehealth. Angela suffered from full cardiac arrest about a year before the Committee's meeting. When she arrived at the Pipestone County Medical Center emergency room, the eHelm in Sioux Falls was immediately called. Though it was Dr. Cooper in the Pipestone ER who was physically with Angela, he was supported by a Sioux Falls cardiologist and was able to stabilize Angela. Her timely transfer was arranged by staff at the eHelm to free up the hands and time of the staff with Angela. She survived and is well today.

¹⁷ Radford, A.D., et al. *Safety Net Clinics Serving the Elderly in Rural Areas: Rural Health Clinic Patients Compared to Federally Qualified Health Center Patients*. Chapel Hill, NC: NC Rural Health Research & Policy Analysis Center, May 2014.

¹⁸ Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Part II – 79 FR 27106

qualified non-physician practitioner. It does allow for telehealth, but it requires the encounter be performed at an eligible originating site.¹⁹ Because home health patients are, by definition and requirement, “homebound,” arranging for and traveling to medical visits poses a hardship for the patient. **The Committee recommends** that the Secretary seek a change in legislation allowing home health certification and re-certification to take place via telehealth equipment within patients’ homes for rural beneficiaries in qualifying telehealth areas. This has the potential to reduce potentially dangerous and costly transports for frail beneficiaries and still allow quality care interventions.

The Committee acknowledges that the expansion in health insurance coverage necessitates changes to—and increases in—the utilization of health care providers. There are ways to make practices more efficient that could enable providers to see more patients. In its August 2013 brief on hospice in rural America, the Committee examined the face-to-face requirements of 180th-day re-certifications for hospice care. The President, through Executive Order 13610, directed the Federal Government to identify and reduce regulatory burden.²⁰ As the Committee was advised in 2013, the face-to-face requirement has not reduced the number of re-certifications, and it is burdensome for hospital physicians, especially those in rural areas. **The Committee reiterates its recommendation** in its August 2013 brief on the Medicare Hospice Benefit that the Secretary seek a change in legislation allowing telehealth consultations to count as face-to-face encounters to certify and re-certify the need for hospice care, as examined in the previous policy brief.

Patient Experiences: Bill

One night, Bill, a patient who is also on the board of the hospital, could not speak. He was rushed to the Pipestone ER by his wife and sister-in-law. In his room, a physician on the screen ordered tests. Bill was having a stroke, and he had a window of three hours to be administered medication that would greatly improve his chances of survival and recovery. From Sioux Falls, helicopter transportation was arranged, and Bill received his injection on the ride over. When he arrived in Sioux Falls, the neurologist on call was already waiting for him at the hospital.

During its site visits, the Committee also discussed the need to establish quality and care metrics for telehealth services. The staff members at each site visit mentioned a reduction in transfers, more timely transfers, and better patient outcomes—including fewer deaths—because of telehealth. However, they lacked externally validated data on clinical outcomes and cost savings. Avera administrators explained that, especially in a large system that serves mostly rural locations, results are aggregated within groups and across time. Though one hospital may have “small” numbers of reductions or improvements, when combined with the other changes at all of the facilities, trends for improvement can be seen. Studies show that telehealth improves access, but less is known about the clinical effectiveness of various telehealth services. Additionally, much of the published literature on these topics is based on small sample sizes. Because quality is so important to pilot programs, payers, and health care systems under the ACA, **the Committee recommends** that the Secretary direct CMS and other HHS agencies to create

¹⁹ Centers for Medicare and Medicaid Services. *A Physician’s Guide to Medicare’s Home Health Certification, including the Face-to-Face Encounter*. Centers for Medicare and Medicaid Services, *MLN Matters* SE1219. Dept of Health and Human Services, 2012, updated April 30, 2014.

²⁰ Exec. Order No. 13610, 3 CFR 2 (2012). Identifying and Reducing Regulatory Burdens.

standardized rural-relevant reporting metrics for telehealth. Furthermore, **the Committee recommends** that the Secretary direct the National Institutes of Health (NIH), the Agency for Healthcare Research and Quality (AHRQ), and/or other HHS agencies to conduct more evidence-based research on telehealth effectiveness, quality, and outcomes in rural areas. By expanding the evidence-base for telehealth, HHS can better target how to best utilize this technology and inform future payment policy for both public and private payers.

Patient Experiences: A Veteran

At the site visit in Howard, the Committee heard from a patient, a veteran, who used the telehealth care there. He needed to see a mental health provider, but the minimum roundtrip to see one in-person was 140 miles, a trip he could not make. Fortunately an alternative was available. He could make appointments at his hometown clinic, sit in a room there, and meet with his provider through video calls. He and his wife appreciated the ability to see their provider without a long and expensive drive, and the patient said that he felt that he could be more open with the provider via telehealth than he would have been in person.

In a recent notice of proposed rulemaking, CMS detailed certain potential waivers for telehealth services and payments in ACOs.²¹ For ACOs that accept more risk, these regulatory changes would expand the use of telehealth by paying for services in patients' homes and in Medicare-approved facilities, regardless of the geographic location. This would ultimately allow for telehealth care to be covered for urban as well as rural patients. However, expanded telehealth use could benefit all ACOs and should not be used as an inducement to accept risk. Telehealth expansion would be particularly useful for rural ACOs, which are less likely, at least initially, to follow the risk-based track.

The Committee recommends that the Secretary extend the waivers of telehealth regulations under the Medicare Shared Savings Program (MSSP) ACO Program proposed rule to all MSSP ACOs. The Committee recognizes that CMS has concerns about potential inappropriate telehealth use within the fee schedule environment. However, because ACO agreements are limited to three years and participants are closely monitored by CMS, these concerns should be largely mitigated.

CONCLUSION

The Committee recognizes the potential that telehealth offers to increase access to and quality of health care in rural America. The Committee is concerned, however, that the current, limited research base on telehealth, along with the restrictions on Medicare and Medicaid reimbursement and recognition of telehealth services as equivalent, may restrict this potential. Telehealth is not detailed extensively in the ACA, but it must be acknowledged as a critical part of the U.S. health care system moving forward, particularly in rural areas. As delivery system reform continues to transition from volume to value, telehealth can provide quality care in rural areas that are challenged by provider shortages and long travel distances. For progress to be made and monitored, regulatory changes must be made to include more telehealth services and reimbursements for those services, and quality must be reported and monitored. The Committee

²¹ "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations; Proposed Rule." *Federal Register* 79 (8 December 2014): 72760-72872. (to be codified at 42 CFR pt. 425).

offers these recommendations on ways to improve access to telehealth services and the quality reporting of these services in hopes that they may reinforce efforts to reform the health care system.