

April 5, 2019

RE: Congressional Telehealth Caucus Request for Information

Dear Congressional Telehealth Caucus:

On behalf of the American College of Emergency Physicians and our 38,000 members, thank you for the opportunity to provide suggestions and recommendations to expand access to and use of telehealth services. We are grateful for your leadership in crafting new legislation that will increase access to innovative, cost-efficient, and effective telehealth and remote monitoring services that can improve patient outcomes and connect more individuals to the health care they need and deserve.

The use of telehealth in emergency departments (EDs) throughout the United States continues to grow, and emergency physicians are well-suited to provide this care. Telehealth can help reduce barriers to care, ensuring patients in rural or underserved areas have access to the lifesaving care they need while remaining in their communities near their families, caretakers, and support systems. Further, in emergency medicine where the difference between life and death can be minutes or seconds, telehealth gives emergency physicians another tool to provide timely medical intervention, even in cases where definitive treatments may not be possible. We believe the work of the Congressional Telehealth Caucus will also help shift the view of telehealth as a somehow distinct type of medicine to a more appropriate understanding of these services—as another tool that physicians and other health care providers can rely upon to deliver the same high-quality care, regardless of setting.

We are deeply appreciative of the telehealth provisions that were included in the Bipartisan Budget Act of 2018 (P.L. 115-123), as these offer a solid foundation for new legislative approaches to eliminate unnecessary regulatory barriers and expand telehealth access. We believe these changes, such as those removing restrictions on geographic locations and originating sites for stroke telehealth services, can inform new congressional efforts moving forward.

More detailed recommendations are provided on the following pages, but listed below are several key priorities we believe Congress should address as well as examples of telehealth models that may be informative for your upcoming legislative efforts:

- 1) **Modify Section 1834(m) of the Social Security Act to include emergency medical services.** Section 1834(m) establishes what specific telehealth services may be reimbursed by Medicare, and does not currently include emergency medicine services. The statute also restricts the provision of telehealth services to specific sites (the originating site requirement) and geographic locations. Entities that want to circumvent these restrictions must apply for waivers, most of which are granted by the Center for Medicare & Medicaid Innovation (CMMI); however, these waivers must be sought on an individual basis and are granted only in limited circumstances.

WASHINGTON, DC OFFICE

2121 K Street NW, Suite 325
Washington, DC 20037-1886

202-728-0610
800-320-0610
www.acep.org

BOARD OF DIRECTORS

Vidor E. Friedman, MD, FACEP
President
William P. Jaquis, MD, FACEP
President-Elect
Stephen H. Anderson, MD, FACEP
Chair of the Board
Jon Mark Hirshon, MD, MPH, PhD, FACEP
Vice President
Mark S. Rosenberg, DO, MBA, FACEP
Secretary-Treasurer
Paul D. Kivela, MD, MBA, FACEP
Immediate Past President
James J. Augustine, MD, FACEP
L. Anthony Cirillo, MD, FACEP
John T. Finnell II, MD, MSc, FACEP
Alison J. Haddock, MD, FACEP
Christopher S. Kang, MD, FACEP
Kevin M. Klauer, DO, EJD, FACEP
Aisha T. Liferidge, MD, MPH, FACEP
Debra G. Perina, MD, FACEP
Gillian R. Schmitz, MD, FACEP

COUNCIL OFFICERS

John G. McManus, Jr, MD, MBA, FACEP
Speaker
Gary R. Katz, MD, MBA, FACEP
Vice Speaker

EXECUTIVE DIRECTOR

Dean Wilkerson, JD, MBA, CAE

In all, they present an unnecessary hurdle to providing telehealth services.

- 2) **Provide funding for telehealth research in emergency medicine.** Federal research funding is a critical resource that will help identify current shortcomings and new opportunities for telehealth implementation. Research funding is also needed to help acquire robust data on outcomes, quality, access, and costs, especially as both Medicare and private payers move toward value-based payment models.
- 3) **Provide assistance to encourage adoption of telehealth services and ensure appropriate reimbursement for emergency telehealth.** Initial startup costs for telehealth programs can be high, even though they increase efficiencies and can result in lower costs once implemented. These capital expenditures can include equipment, training, technical support, and additional personnel, and can be significant enough that they effectively limit uptake of telehealth services. Additionally, telehealth services, like other health care services, should be reimbursed at a fair market value for the services rendered. Telehealth services enable care and expertise to be provided to patients in locations where needed specialty care is not otherwise accessible because of cost or lack of availability of a particular specialty.
- 4) **Real-world examples can help inform legislative efforts.** Innovative telehealth initiatives have helped improve care and lower costs across the country, in both urban and rural areas. Different types of emergency care models have been tested, from “direct-to-consumer” models to models that involve a hub that connects emergency physicians to EDs in remote locations or allows emergency physicians to provide consultations for specific clinical conditions. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions.

Once again, thank you for the opportunity to respond to this request for information. Should you have any questions or need any additional information, please do not hesitate to contact Ryan McBride, ACEP Senior Congressional Lobbyist, at rmcbride@acep.org.

Sincerely,



Vidor Friedman, MD, FACEP
ACEP President

Cc:

Representative Mike Thompson
Representative Dave Schweikert
Representative Peter Welch
Representative Bill Johnson
Senator Brian Schatz
Senator John Thune
Senator Mark Warner
Senator Roger Wicker
Senator Ben Cardin
Senator Cindy Hyde-Smith

1) **Modify Section 1834(m) of the Social Security Act to include emergency medical services, and eliminate geographic location originating site restrictions.**

There are established examples of high quality, cost-effective telehealth programs in the emergency department (ED) setting that allow greater access to an emergency physician in inner city or rural EDs that would not normally be able to economically support that level of provider on a 24/7 basis, if at all. Additionally, telehealth access from the ED setting to other medical specialists such as neurologists or psychiatrists can help provide faster access to specialty care and reduce delays in critically needed treatment and the time these patients remain in the ED waiting for a psychiatric bed to become available (i.e. ED “boarding”).

As more and more small and rural hospitals close, their EDs close too, leaving a gap in emergency care in a region. To fill these gaps, emergency physicians housed in what may be a state’s only large or teaching hospital provide telehealth services to patients and providers in smaller rural or community hospitals that are staffed by registered nurses (RNs) and Advance Practice Nurses (APNs). These valuable services provide clinical expertise in real time to stabilize patients who may need to be transferred long distances or may be observed at timely intervals over several hours by the emergency physician team at the teaching hospital before a decision is made to transfer, admit locally, or release the patients.

Section 1834(m) of the Social Security Act (SSA) establishes the specific telehealth services that may reimbursed by Medicare. Emergency medicine services currently are not included in this list of eligible services. The most straightforward approach to address this issue is to simply add emergency services (CPT codes 99281-99285), and observation services (CPT codes 99217-99220; 99224-99236; and, 99234-99236) to the list. These codes can be added either through statutory changes or through the regulatory process under the discretion of Secretary for Health and Human Services (HHS). ACEP has urged the Centers for Medicare & Medicaid Services (CMS) on several occasions to include these codes on the list of approved telehealth services billable under Medicare, but to date, they have not been added. Unfortunately, the regulatory criteria that CMS has established for adding new codes to this list are extremely stringent, and CMS has determined that the emergency services codes do not meet these unattainable standards. We believe a statutory fix to add emergency services to the list already included under Section 1834(m) of the SSA would be the simplest and most effective way to reduce artificial barriers that hinder adoption of emergency telehealth and so we encourage Congress to add emergency medicine services codes.

To maximize the impact that the provision of emergency telehealth services can have on patients across the country, we also need to eliminate the current statutory restrictions that limit telehealth services to specific sites (the originating site requirement) and geographic locations. Currently, entities that want to circumvent these restrictions must apply for waivers, most of which are granted by the Center for Medicare & Medicaid Innovation (CMMI); however, these waivers must be sought on an individual basis and are granted only in limited circumstances. In all, they present an unnecessary hurdle to providing telehealth services. ACEP supports the full removal of the originating site and geographic site requirements for emergency services, expanding upon the provision that was ultimately included in the Balanced Budget Act of 2018 (P.L. 115-123) for just telestroke services. We believe a similar approach is appropriate, necessary, and achievable for all emergency medical services.

2) **Provide funding for telehealth research in emergency medicine.**

Federal research funding is a critical resource that will help identify current shortcomings as well as new opportunities for telehealth implementation. Research funding is also needed to help acquire robust data on outcomes, quality, access, and costs, especially as both Medicare and private payers move toward value-based payment models.

Though studies and real-world examples have shown the value of care delivered via telehealth, this tool is still relatively new and rapidly developing. As such, policies for reimbursement for telehealth in emergency services

have yet to be fully defined. Additional data on quality, cost, access, and outcomes are needed to help both CMS and third-party payers evaluate and establish appropriate reimbursement for these services.

Such data will also be invaluable for lawmakers as additional telehealth legislation is considered. As you well know, the underlying methodology for many cost estimates of telehealth legislation does not take into account the future savings generated through prevention or improved outcomes. Federally-supported research and data can help address these shortcomings and highlight the value of telehealth.

An analysis of 58 systematic reviews of telehealth outcomes issued by the Agency for Healthcare Research and Quality (AHRQ) found that telehealth interventions resulted in positive outcomes and were effective in applications such as remote patient monitoring, managing patients with certain chronic conditions, and behavioral health interventions.¹ It also found measurable improvements in mortality rates, quality of life, and reduction in hospital admissions. Importantly, the technical brief further notes that given the sufficient evidence of effectiveness for these topics, “future research should shift to implementation and practice-based research.”

3) Provide assistance to encourage adoption of telehealth services and ensure appropriate reimbursement for emergency telehealth.

Initial startup costs for telehealth programs can be high, even though they increase efficiencies and can result in lower costs once implemented. These capital expenditures can include equipment, training, technical support, and additional personnel, and can be significant enough that they effectively limit uptake of telehealth services. Overall, telehealth services, like other health care services, should be reimbursed at a fair market value for the services rendered. Telehealth services enable care and expertise to be provided to patients in locations where needed specialty care is not otherwise accessible because of cost or lack of availability of a particular specialty.

New demonstration projects through CMMI can offer one potential pathway for covering and paying for emergency telehealth services. However, there are two issues we face with CMMI.

First, CMMI models, like the Next Generation Accountable Care Organization (ACO) Model, only waive the geographic and originating site restrictions – important, to be sure, but they do not provide any financial assistance or incentives to mitigate the initial startup costs. Providing some financial assistance on the front end through new CMMI models, or even other modest investments via federal grants, guaranteed loans, or pilot program opportunities can help smaller or more rural facilities ease the burden of those initial capital expenses and expand the reach of new telehealth programs.

Second, there are currently no alternative payment models (APMs) that emergency physicians can directly participate in. Although emergency physicians play a significant role in our healthcare system—making critical decisions every day about whether their patients should be kept for observation, admitted to the hospital, or discharged— they have no opportunity to be meaningful participants in value-based arrangements and APMs. To address this gap in available models, ACEP developed an APM called the Acute Unscheduled Care Model (AUCM) that is focused on Medicare providers and beneficiaries. On September 6, 2018, a federal advisory committee called the Physician-Focused Payment Model Technical Advisory Committee (PTAC) recommended the AUCM to HHS Secretary for full implementation. The Secretary is currently reviewing the PTAC recommendation and we are waiting for the Secretary’s detailed response. While we are hopeful that the HHS Secretary will instruct CMMI to move forward with the model, we do note that up until now, CMMI has yet to implement an APM recommended by the PTAC.

¹ Agency for Healthcare Research and Quality, “Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews,” June 2016. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/telehealth_technical-brief.pdf.

The AUCM focuses on improving care and reducing costs for Medicare beneficiaries. The model enhances the ability of emergency physicians to reduce inpatient admissions and observation stays when appropriate through processes that support care coordination and consider patient preference. Emergency physicians become members of the continuum of care as the model focuses on ensuring follow-up, minimizing redundant post-ED services, and avoiding post-ED discharge safety events that lead to follow-up ED visits.

A key component of the AUCM is the ability of participating emergency physicians to provide telehealth services under the same waiver, referenced above, that was put in place in the Next Generation ACO Model and other APMs. There is a great opportunity for physicians to use telehealth to improve patient care in this model. In one possible scenario, a patient has been transferred by an initial treating rural or small hospital to a tertiary care center for potential admission. Upon evaluation and treatment, it is determined that they do not require admission. In this case, the follow up visit might occur at a rural clinic or hospital that has telehealth capabilities. A second scenario might occur when patients are sent to assisted living facilities that may have telehealth capabilities in place.

4) **Real-world examples can help inform legislative efforts.**

Innovative telehealth initiatives have helped improve care and lower costs across the country, in both urban and rural areas. Different types of emergency care models have been tested, from “direct-to-consumer” models to models that involve a hub that connects emergency physicians to EDs in remote locations or allows emergency physicians to provide consultations for specific clinical conditions. In general, studies have shown that physicians and patients are extremely satisfied with the care being provided through these models, and costs have decreased due to avoided ED visits and inpatient admissions.

Some successful programs of note include:

- In Pennsylvania, Jefferson Health has implemented the JeffConnect Program, which connects Jefferson emergency physicians to patients 24 hours a day seven days a week through On-Demand Video Visits. This initiative has been extremely successful in treating patients with stomach aches, flu symptoms, and for other similar conditions. Results from the program have been promising:
 - 83 percent of patients reported that they would have sought treatment elsewhere—of these, 45 percent would have higher cost ED or urgent care visits.
 - Cost savings to the patient or payer is \$19 to \$121 per episode of care, taking into account alternate care sites and post-visit care.

Also in Pennsylvania, the Lehigh Valley Health Network’s Advanced ICU (AICU) has showed a significantly lower mortality rate (31 percent relative mortality risk reduction) and a lower rate of the use of mechanical ventilation. The AICU is an off-site monitoring center staffed by a team of physicians that monitors all intensive care patients and can immediately flag changes in vital signs and quickly alert the patient’s ICU team.²

- In December 2014, the city of Houston initiated ETHAN (Emergency Telehealth and Navigation), a program that helps redirect 9-1-1 callers who have non-emergent conditions to alternative locations besides the ED. Under the model, paramedics responding to patients on the scene can connect remotely to an ETHAN emergency physician located at a command center. The emergency physician can help provide a clinical assessment of the patient and determine the best course of action, which could include a non-ambulance transport to a primary care or urgent care clinic.

² More information on the AICU can be found at:

https://www.lvhn.org/our_services/key_support_services/virtual_health_apccci/advanced_intensive_care_unit_aicu.

- Emory University Hospital has just completed a successful pilot study focusing on care delivered in their emergency department observation units (EDOUs). Most U.S. hospitals do not have protocol-driven EDOUs despite their documented benefits. The observational study took place in Emory's academic hospital 8-bed ED OU. During a six-day period, the ED attending supervising the ED OU participated in morning patient rounds entirely via a telehealth device which an advanced practice provider (APP) carted into patient rooms. Immediately after, the same ED attending physician re-examined all patients in person to determine if tele-rounding missed any clinical details. The study found that there were no patient history or examination findings that were missed due to telehealth. The goal of this project, once fully established, would be to use telehealth to oversee remote observation units across numerous hospitals.
- The University of Mississippi Medical Center (UMMC) in Jackson, Mississippi provides emergency medicine specialist expertise to advance practitioners in approximately 20 to 30 rural EDs throughout the state of Mississippi. Many of these EDs may have closed without the UMMC program providing emergency physician back-up and support to the mid-level providers on-site. Since the program's inception, over 500,000 patients have had access to board certified emergency medicine specialists without ever leaving their small community. UMMC was recognized by the Health Resources and Services Administration in 2017 as a Center of Excellence in Telehealth for its work and accomplishments in telehealth.
- Avera Health based in Sioux Falls, SD provides telehealth services through a program called eCARE to approximately 440 unique health care facilities in 25 states; 200 of which are rural hospitals. The model centers around a telehealth hub which is staffed 24 hours a day by an interdisciplinary team of physicians, nurses, pharmacists, and social workers. During an eCARE shift, clinicians only see patients via telehealth and are attuned to the specific needs of the rural facilities. Started in 2009, eCARE has provided instant access to board-certified emergency physicians and critical care nurses who operate as a part of the rural emergency team. The eCARE emergency team can expedite care, bring in specialists, assist with patient codes, call in support staff, and arrange transfers or whatever else is needed during a critical emergency case. Results to date include:
 - \$49,841 in average annual savings to hospitals, because of better staffing options³
 - Potential to result in net savings of \$3,823 per avoided Emergency transfer⁴
 - \$117,406 decrease in total ED costs⁵
 - \$30 million saved in avoided transfers
- In the remote international port in the Aleutian Islands in Alaska, Iliuliuk Family and Health Services has partnered with emergency physicians and critical care doctors at Anchorage Hospital, more than 800 miles away, to respond to emergencies. While the volume of cases is low, there are occasionally high-acuity emergent cases. Using satellite technology, primary care physicians can consult with emergency physicians in Anchorage to stabilize patients and prevent the need to have them transported to a hospital that is hundreds of miles away.

³ MacKinney AC, Ward MM, Ullrich F, Ayyagari P, Bell AL, Mueller KJ. The Business Case for Tele-emergency. *Telemed J E Health*. 2015 Dec;21(12):1005-11. <http://www.ncbi.nlm.nih.gov/pubmed/26226603>.

⁴ Natafgi N, Shane D, Ullrich F, MacKinney C, Bell A, Ward M. (2017). Using Tele-Emergency to Avoid Patient Transfers in Rural Emergency Departments: An Assessment of Costs and Benefits. *Journal of Telemedicine and Telecare*. March 7, 2017. doi: <https://doi.org/10.1177/1357633X176965854>.

⁵ Ward M, Merchant AS, Carter KD, Zhu X, Ullrich F, Wittrock A, Bell A. (2018) "Use of Telemedicine For ED Physician Coverage In Critical Access Hospitals Increased After CMS Policy Clarification." *Health Affairs (Millwood)*. 2018, 12, 37. doi: 10.1377/hlthaff.2018.051032.