

Congressional Elective

# My AAEM/RSA Congressional Elective Experience

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My congressional elective experience through AAEM was an incredible, zoomed-in, view of how our congressional process works. The work I did was largely split into two different tasks. The first was day-to-day health policy research and data gathering for the office as the Congressman sought to reinforce and advance his health policy positions. The Congressman has an incredibly deep understanding for domestic health policy drawing both from his role directly involved in patient care as an emergency physician and also stemming from his extensive education in health policy receiving advanced degrees at the Harvard Kennedy School of Government and the Harvard School of Public Health. He buttressed this domestic health policy expertise by training as an International Emergency Medicine Fellow at Brigham and Women's Hospital, doing international relief work in Haiti, and by serving as a consultant to the Ministries of Health of both Serbia and El Salvador. When he needed to have specific information to help inform his position on a crucial decision, I worked with the team including other health policy fellows and congressional staffers in the office to gather this data and helped to present it in a way that was concise and useful.

I also sat in on Congressional hearings and briefings germane to the Congressman's health policy interests. I learned an incredible amount at the Congressional Hearing on the DEA's role in preventing the opioid crisis and what more could be done from its vantage point. I was blown away at a Congressional briefing by the American Public Health Association on the specific ways in which Congress can come together to promote sensible gun control policy.

The highlight of these briefings however, was a briefing on 'Strategies to Increase Access to Quality Health Care in Rural America' convened by the Congressman himself on the role of telehealth in rural communities. Among the invited speakers were: The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI), Directors from Farmworker Justice, Vista Community Clinic, and Campesinos Sin Fronteras, and they all spoke with rare clarity about the specific needs presented by patients living in rural communities all across America.

This briefing served as the foundation for the other important part of my work in the Congressman's office. He sought to explore federal legislative reforms that would allow telehealth to be used as a vehicle to serve patients with limited access to care nationally. Segments of his district are composed of rural farmworkers who would benefit from increased access to health care. The Congressman has been focused on how to bring

quality, cost-effective, timely health care to these constituents who previously have not had easy access to primary and specialist care.

Telehealth services offer an opportunity to do this but currently there are several legislative barriers that are affecting telehealth spread in rural populations and it was my job to better understand the nature of those barriers so we could explore legislative solutions that addressed and removed those barriers, where possible. The constellation of legislative ideas that came out of determining how these legislative barriers would be addressed may serve as the foundation for a new legislation that could then be molded by the Congressman and his staff to a workable solution.



I spent the last few weekends in D.C. exploring, seeing the beautiful kaleidoscope of colors in the blooming cherry blossoms on the National Mall, appreciating the Martin Luther King Memorial 50 years after his death, and hearing the chants from our nation's youth for smart gun control policy during the March for Our Lives march on the Capitol. I came to experience D.C. at an interesting time in our nation's history and it will have a lasting impact on both my professional and personal development. I will be forever grateful to the Congressman, his exceptional staff, and the team at AAEM and AAEM/RSA who worked to make this unique opportunity possible.

## Policy Paper

Residents of rural areas experience significant challenges in accessing quality health care. Broadening the use of telehealth is one promising strategy for increasing access to care in rural communities. Despite the promise of telehealth for improving access in rural areas, however, there are seven distinct federal policy barriers which impede the proliferation of telehealth capacity in rural areas. These span several areas: reimbursement restrictions, limitations on broadband infrastructure, and onerous CMS administrative rules. It is only by understanding the nature of these seven federal barriers to using telehealth as a means to increase health care access in rural areas can we identify potential legislative opportunities to address these barriers.

## Seven Barriers to Expansion of Telehealth in Rural Communities

### Store and Forward Restrictions

Background: Store and Forward is the transmission of medical information, such as digital images, to a provider who uses the information to

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evaluate the case outside of a real-time or live interaction. Example: A PCP sends an image of a suspicious skin lesion to a distant dermatologist, who can review the image and determine the need for an in-person visit.

*Barrier:* Currently Medicare reimbursement of this service is only permitted in Alaska and Hawaii.

### Remote Patient Monitoring (RPM) Restrictions

Background: RPM is the transmission of personal health data from a patient in one location to a provider in a different location. Example: A rural patient with a painful red lesion on their leg can record their temperature with a connected health device and have this automatically pushed to his PCP who can trend their fever curve.

*Barrier:* Currently, Medicare does not reimburse for RPM services for general Medicare beneficiaries. It does reimburse specific RPM services for beneficiaries who have Medicare Advantage.

### Originating Sites Restrictions

*Barrier:* In order for a provider to be reimbursed for telehealth services Medicare requires that the patient be present at an “originating site,” such as a physician’s office, federally qualified health center, clinic, or hospital. Furthermore, this originating site has to be in a “rural health profession shortage area,” in counties that are not included in a metropolitan area. Medicare will not cover telehealth services if the patient is at home during the provision of care except in two conditions: telestroke evaluation and care for at home dialysis patients.

### Provider Type Restrictions

Background: Currently, only Medicare defined “practitioners” may be reimbursed for telehealth services. This list includes physicians, nurse practitioners, physician assistants, nurse midwives, clinical nurse specialists, clinical psychologists and clinical social workers, registered dietitians, and nutrition professionals. Rural communities face numerous health care challenges, including: hospital closures, lack of access to health care services, health care professional shortages and lack of culturally appropriate services. Community Health Workers (CHW), or Promotores de Salud in Spanish-speaking communities, are the backbone of the primary care network in rural health areas because they are able to expand access to health services in areas where transportation and provider shortages pose a problem

*Barrier:* CHWs are currently not an approved telehealth “practitioner” type by Medicare.

### Broadband Limitations

Background: Rural health clinics require stable and fast broadband connection speeds in the range of 50-100 Mbps connection to engage in quality telemedicine. Currently, the majority of rural health clinics operate on a broadband connection speed that is far below the broadband requirement to initiate Telehealth services. Roughly 60 percent of rural health clinics have broadband connections less than 10 Mbps.

*Barrier:* The Federal Communication Commission’s Rural Health Care (RHC) program, a program dedicated to helping rural health areas expand access to broadband has an annual cap of \$400 million. This was

set 20 years ago given demands at that time. Experts state that this cap does not meet the current need for broadband access in rural communities and that an \$800 million annual cap more accurately reflects current needs to establish adequate broadband capabilities.

### Underfunded Telehealth Resource Centers

Background: Fourteen federally designated Telehealth Resource Centers around the country currently offer extensive hands-on experience in telemedicine development for providers seeking to expand their telehealth efforts. Resource centers provide technical assistance, program support, and help providers establish best practices in telehealth reimbursement and operations.

Barriers: Funding shortfalls consistently plague TRCs which constrain their ability to provide support to rural health providers considering telehealth.

### Restrictions on Billing for Multiple Visits and Definition of a Visit

Background: The main source of primary care in rural communities occurs in FQHCs. Medicare has imposed restrictions on billing for multiple visits for the same patient in one day except in cases of an emergency or a new chief complaint. Medicare will allow billing for multiple visits in one day for the following scenarios: mental health, dental health, and nutritional evaluation.

*Barrier:* Many patients in rural health areas inconsistently seek medical attention and have a disproportionately high no show rate for follow up visits. When they are present at their FQHC and being evaluated by their PCP they cannot stay on site that day to receive another telehealth specialist evaluation except in the above scenarios.

### Conclusion

The promise of telehealth in rural areas can only be fully actualized through addressing federal policy barriers which currently impede its widespread adoption. Legislators interested in expanding access to telehealth should consider federal legislative reforms that:

- cover store and forward services in designated rural health areas.
- expand the list of covered conditions that can be reimbursed in the home to include conditions affecting rural workers like diabetes, hypertension, asthma, and obesity.
- include CHWs as a reimbursable telehealth provider.
- increase funding to the FCC’s Rural Health Care (RHC) program which could be designated to building the broadband infrastructure needed to support telehealth efforts in rural health areas.
- increase DHHS funding to resource centers that contain large portions of rural health areas could be proposed to help in these efforts.
- mandate that CMS remove the restriction on reimbursement of multiple visits in FQHCs in rural health areas if care is being given by telehealth.

The effective use of telehealth in rural communities, paired with the necessary legislative changes outlined above, has the potential to dramatically improve both access to care and quality of care in rural communities across the nation for years to come. ●