



ALLIANCE *for*
CONNECTED CARE

June 16, 2014

The Honorable Fred Upton
Chairman
Energy & Commerce Committee
U.S. House of Representatives

The Honorable Henry Waxman
Ranking Member
Energy & Commerce Committee
U.S. House of Representatives

The Honorable Joe Pitts
Chairman
Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives

The Honorable Frank Pallone, Jr.
Ranking Member
Subcommittee on Health
Energy & Commerce Committee
U.S. House of Representatives

Dear Chairmen and Ranking Members:

The Alliance for Connected Care (the “Alliance”) is pleased to have the opportunity to respond to the request for comments on how to realize the promise of telehealth. In particular, we are responding to the request for policy and legislative ideas on how the federal government can support the adoption of telehealth and the existing barriers that hinder its adoption.

The Alliance is a 501(c)(6) organization formed to create a statutory and regulatory environment in which every provider in America is permitted to deliver and be adequately compensated for providing safe, high quality care using Connected Care at his or her discretion, regardless of care delivery location or technological modality. Our members are leading health care companies from across the health care spectrum, representing insurers, retail pharmacies, technology companies, telecommunications companies, and health care entrepreneurs. The Alliance works in partnership with an Advisory Board that includes over 20 patient and provider groups.

As reflected in the comments below, the Alliance is committed to modernizing our health care system for the benefit of patients, providers, and payers alike. Our comments focus on the following: (1) the impact of Connected Care on health care access, quality, and costs; (2) the current federal statutory and regulatory barriers to its adoption; and (3) initial recommendations for the Subcommittee on Health (the “Subcommittee”) to consider as part of its effort to explore how 21st century technology can contribute to a higher quality and more efficient health care system.

Improving Health Care Access, Quality, and Reducing Costs with 21st Century Technology

Telehealth technologies and services or “Connected Care” is critical to modernizing our health care system. Connected Care is the real-time, electronic communication between a patient and a

provider, including telehealth, remote patient monitoring, and secure email communication between clinicians and their patients. With the development of innovative health care technologies and the implementation of new care delivery and payment models, Connected Care is offering new and more efficient ways to furnish health care to patients. Indeed, through Connected Care, health care providers can remotely communicate with their patients and other health care providers across care settings through iPads, laptops, and smartphones, patients and their caregivers can be more engaged in the delivery of their own care, and patients with limited access to health care providers can be treated in less costly and more convenient care settings, such as their homes and local retail clinics.

Increasingly, there is evidence to demonstrate how the benefits of Connected Care are improving health care access and quality, and reducing costs for payers. This is particularly true for patients with multiple chronic conditions, which affects over two-thirds of Medicare beneficiaries.¹ A recent University of Michigan and University of Kentucky literature review demonstrates the impact of Connected Care on health care access, quality, and costs, focusing on three chronic diseases – congestive heart failure (“CHF”), stroke, and chronic obstructive pulmonary disease (“COPD”).² Among CHF patients, telemonitoring was significantly associated with reductions in mortality ranging from 15 percent to 56 percent as compared to traditional care. Meanwhile, telestroke provides an advantage for stroke patients without readily available access to stroke specialists. The various modalities of telestroke have demonstrated the ability to reduce mortality in the range of 25 percent during the first year after the event. In addition, there is evidence to support the economic benefit of telemonitoring among CHF, stroke, and COPD patients, as measured by changes in hospital admission and readmission rates and cost-benefit analyses.

The findings of the literature review are proving true in health care settings across the country. St. Vincent Health – a member of Ascension Health and Indiana’s largest health care system – conducted a study to determine the impact of a remote care management program on patients with CHF and COPD recently discharged from the hospital. During the 30-day follow-up period, the remote care management program included daily monitoring of patient biometrics (e.g., blood pressure, body weight), interactive daily questionnaires, and video conferencing. Initial results showed a reduction in hospital readmissions to 5 percent as compared to 20 percent in the control group – a 75 percent reduction. Translated to the Medicare program, which spends an estimated \$26 billion on readmissions annually, of which over \$17 billion is preventable, this type of Connected Care program could significantly reduce program costs, while improving beneficiary outcomes.³

For the 26 million people living with type 2 diabetes, clinical care delivered through telemonitoring has shown statistically significant improvements in clinical markers, such as A1c

¹ Centers for Medicare & Medicaid Services (CMS), “Medicare Dashboard Advances ACA Goals For Chronic Conditions,” Press Release (March 28, 2013).

² Rashid L. Bashshur, et al. “The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management” (made available May 2014) (to be published in TELEMEDICINE AND EHEALTH).

³ The Robert Wood Johnson Foundation, “The Revolving Door: A Report on U.S. Hospital Readmissions - An Analysis of Medicare Data by the Dartmouth Atlas Project” (February 2013).

levels, as compared to usual care.⁴ In addition, mobile phone technology is becoming a useful tool in managing the disease. In a 2011 study of 163 patients over 26 primary care practices, the combination of mobile coaching with blood glucose data, lifestyle behaviors, and patient self-management data individually analyzed and presented with evidence-based guidelines to providers substantially reduced A1c levels over a one year period.⁵

Beyond improving chronic care management, Connected Care is increasing access to high quality primary care. In a recent study, the RAND corporation analyzed the experiences of 300,000 members of the California Public Employees' Retirement System ("CalPERS") who used telehealth services.⁶ Teladoc, one of the largest telehealth providers in the country, provided the services over the course of almost a year. The study found that patients who participated in Teladoc "visits," which consists of remote physician consultations by phone or internet, were less likely to require follow-up visits for a similar condition in any setting. Only 6 percent of patients sought follow-up care as compared to 13 percent who visited a physician office or emergency department. While cost savings were not the focus of the study, the RAND authors noted that the \$38 Teladoc visit as a replacement for physician office and emergency department visits could generate savings for payers. This could also translate into considerable savings to patients. It is estimated that if 25 percent of primary care office visits were conducted through Connected Care, Americans would save \$1.2 billion annually in light of current wait times and upward of \$5 billion, taking into account travel time to the physician.⁷

In addition, home care providers and agencies are using remote patient monitoring to provide more proactive and timely care to their patients to help prevent costly interventions. Windsor Place Home Health in Windsor, Kansas, deployed telehomecare for its chronically ill Medicaid patients.⁸ In doing so, hospital readmissions, emergency room visits, and nursing home admissions were reduced to zero over a one year period. Total cost savings over the same time period was approximately \$1.3 million, while the per patient cost of the intervention was only \$6 per patient per day. Likewise, at Forrest General Home Care and Hospice in Mississippi, targeted telehomecare for patients with CHF and COPD caused hospitalization rates to drop from 20 percent to 3 percent and emergent care rates to fall from 7 percent to 2.5 percent over the course of a year.⁹

Connected Care has also shown the potential to contribute to improved medication adherence, which the Congressional Budget Office is now using to offset Medicare program spending for medical services.¹⁰ The George Washington University Medical Center conducted a study to

⁴ Parks Associates, "Implementing an Enhanced Care Management Program Utilizing Telemonitoring Delivers Improvements in the Quality of Care for Patients with CHF, COPD, or Diabetes" (May 2013).

⁵ Charlene C. Quinn, et al. "Cluster-Randomized Trial of a Mobile Phone Personalized Behavioral Intervention for Blood Glucose Control," *DIABETES CARE* (published online July 25, 2011).

⁶ Lori Usher-Pines and Ateev Mehrotra. "Analysis of Teladoc Use Seems to Indicate Expanded Access to Care for Patients without Prior Connection to a Provider," *HEALTH AFFAIRS* (February 2014).

⁷ The Information Technology & Innovation Foundation, "Unlocking the Potential of Physician-to-Patient Telehealth Services" (May 2014).

⁸ The National Association for Home Care & Hospice, Statement to the House Energy and Commerce Subcommittee on Health (May 21, 2014).

⁹ *Id.*

¹⁰ Congressional Budget Office, "Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services" (November 2012).

determine the impact of a Pill Phone mobile application on medication adherence in a group of 50 randomly selected Medicaid patients.¹¹ On average, patients agreed or strongly agreed that having the Pill Phone made it easier to keep track of their medications and indicated they would use the Pill Phone or similar program in the future. There was a trend toward increased prescription refill rates with the use of the Pill Phone application and a decrease after the application was discontinued. There was a significant increase in self-reported medication adherence scores over the course of the study.

Finally, Connected Care can also help ensure greater patient access to specialty services. Studies have found that Dermatologists can diagnose and treat patients just as effectively through store-and-forward technology or video conferencing as they can in-person.¹² According to Kaiser Permanente Northern California, dermatologists have been able to diagnose and treat 80 percent of their cases through virtual encounters alone.¹³

The abovementioned examples represent only a handful of the ways in which Connected Care is creating new ways to enhance care access, quality, and coordination. Importantly, these technologies also have the potential to generate savings for patients and the health care system.

Barriers to the Adoption of Connected Care

Despite the impact of Connected Care on health care access, quality, and costs, the current federal statutory and regulatory framework has failed to keep pace with innovation, hindering its adoption. For purposes of our comments, we have addressed the following barriers: (1) coverage and reimbursement restrictions; (2) lack of a universal definition; and (3) multistate licensure.

Coverage and Reimbursement Restrictions

As part of the Medicare, Medicaid and SCHIP Benefits Improvement Protection Act of 2000, Congress added section 1834(m) of the Social Security Act (the “Act”) to expand Medicare coverage and reimbursement for telehealth services. Specifically, under section 1834(m), the Medicare fee-for-service program covers and reimburses for telehealth services furnished to beneficiaries located at “originating sites” in rural Health Professional Shortage Areas (“HPSAs”) or counties outside of Metropolitan Statistical Areas (“MSAs”).¹⁴ As defined, originating sites include physicians’ or practitioners’ offices, hospitals, rural health clinics, skilled nursing facilities, critical access hospitals (“CAHs”), federally qualified health centers, community mental health centers, and hospital-based or CAH-based renal dialysis centers.

Based on these geographic and site restrictions, Medicare beneficiaries who live in medically-underserved urban areas or are homebound are unable to benefit from Connected Care. There is

¹¹ The George Washington University Medical Center, “The Medication Adherence and mHealth: The George Washington University and Wireless Reach Pill Phone Study,” Case Study (July 2012).

¹² John S. Barbieri, et al. “The Reliability of Teledermatology to Triage Inpatient Dermatology Consultations,” JAMA DERMATOLOGY (February 12, 2014).

¹³ Robert Pearl. “Kaiser Permanente Northern California: Current Experiences with Internet, Mobile, and Video Technologies,” HEALTH AFFAIRS (February 2014).

¹⁴ 42 U.S.C. § 1395m(m)(4)(C).

no coverage for about 80 percent of Medicare beneficiaries who live in the areas of the country that are not considered “rural.” To further illustrate this point, in 2009, there were more than 43 million Medicare beneficiaries, yet only 14,000 received telehealth services. In other words, only a fraction of a percent of Medicare beneficiaries are accessing telehealth services compared to the millions in the commercially insured marketplace. In dollar terms, Medicare pays about \$6 million for telehealth services compared to the more than \$3 billion paid to providers in one year under the electronic health record incentive programs.

While beneficiaries living in rural areas face unique barriers in accessing health care providers and services, many beneficiaries living in metropolitan areas face similar obstacles. The shortage of health care providers, including specialty providers, extends beyond rural areas, making the current distinction between rural and suburban areas futile. As more individuals enter the health care system, this problem will only be amplified. Not to mention, advances in Connected Care technology have spurred opportunities that were unimaginable over a decade ago when Congress enacted section 1834(m). From working mothers using video-based applications to remotely connect to a primary care provider for their sick children, to visiting a local retail clinic on the weekend for a remote consultation, Connected Care has the potential to truly modernize health care delivery in this country if current reimbursement and coverage limitations are lifted. It is time for Medicare to allow wider access to these innovative technologies for patients.

Lack of a Universal Definition

The lack of a universally accepted definition of Connected Care across payers presents another barrier to its adoption. According to a recent study, there are seven federal definitions of telehealth.¹⁵ The Medicare program defines a “telehealth service” as a limited number of Part B services, including professional consultations, office visits, and behavioral counseling, and psychiatric services.¹⁶ Further, in most instances, Connected Care technology includes only interactive telecommunications technology that allows for real-time communication between the patient and provider. The Medicare telehealth benefit does not include asynchronous technologies (except in limited instances), telephone, and remote patient monitoring in its definition of covered technologies.

Although the Medicare program often sets the precedent for other payers, private payer and State Medicaid coverage and reimbursement for Connected Care varies by state. Currently, 46 State Medicaid programs provide some level of reimbursement for telehealth services and 20 states and the District of Columbia mandate some level of private coverage.¹⁷ While these payers are typically more expansive in their definition of Connected Care technology and services, the inconsistency among payers has created a fragmented structure such that access to Connected Care is dependent on the state where the patient resides. A standard definition for high quality, safe, and secure Connected Care that is broad and flexible enough to incorporate both existing and new advancements in Connected Care technologies is critical to ensuring access to all

¹⁵ Charles R. Doarn, et al. “Federal Efforts to Define and Advance Telehealth—A Work in Progress,”

TELEMEDICINE AND E-HEALTH (May 6, 2014).

¹⁶ 42 U.S.C. § 1395m(m)(4)(F).

¹⁷ National Telehealth Policy Resource Center, Medicaid *available at* <http://telehealthpolicy.us/medicaid>.

patients. Any definition of Connected Care must also ensure that appropriate standards are in place to ensure the delivery of medically necessary care to patients through private and secure technologies.

Multistate Licensure

The existing medical licensing framework is also a barrier to Connected Care. State Medical Boards are tasked with setting the standards and conditions for physician licensure in their state, and each state medical board has a unique application process, different fees, and widely varying processing times. As a general matter, physicians must be licensed in the state in which they practice medicine. With limited exceptions, the provision of Connected Care requires the physician to be licensed in the state where the patient is receiving the telehealth services. As a result, licensed physicians furnishing Connected Care often must obtain multiple licenses – a license for the state in which they practice medicine and any state where their patients reside and are receiving care. Unfortunately, the process for applying for multiple licenses is administratively burdensome and even cost prohibitive. Addressing these licensure limitations is central to enabling Connect Care to increase access and make more uniform the quality of care for patients.

To address multistate licensure, industry and provider stakeholders and several policymakers are exploring alternatives, such as a Medicare license for physicians furnishing telehealth services to Medicare beneficiaries, or streamlining the current licensure process to make it easier for physicians to obtain multiple licenses. One approach is through a multistate compact that enables licensure reciprocity, such as the Nurse Licensure Compact.¹⁸ The Alliance believes a simpler licensure framework is necessary to more effectively enable physicians to provide high quality, safe, and secure telehealth services to patients across the country.

Policy and Legislative Recommendations to Advance the Promise of Connected Care

The Alliance applauds the Subcommittee for its efforts to advance the adoption of Connected Care. Our members are deeply committed to the promise of Connected Care for patients, providers, and payers. As the Subcommittee considers various policy and legislative ideas, we urge the Subcommittee to consider the following initial recommendations to support the adoption of Connected Care.

- **Lift geographic and site restrictions.** We recommend that Congress lift section 1834(m) geographic and originating site restrictions from the Medicare fee-for-service telehealth services benefit. Eliminating these restrictions would enable Medicare beneficiaries to receive Connected Care services in less costly settings, such as a beneficiary’s home, ensure fair access to Connected Care services for all beneficiaries, regardless of whether they live in rural or metropolitan areas, and improve care coordination and outcomes for the Medicare population. A new construct is needed to

¹⁸ National Council of State Boards of Nursing, Nurse Licensure Compact *available at* <https://www.ncsbn.org/nlc.htm>.

ensure that all beneficiaries can benefit from high quality, more convenient, and less costly care.

- **Establish a multistakeholder approach to define Connected Care.** We recommend that Congress require the Secretary of the Department of Health and Human Services (the “Secretary”) to establish a multistakeholder process to develop a standard definition for high quality, safe, and secure Connected Care that can be used across all payers. As part of this process, we encourage the Secretary, through the Office of the National Coordinator, to engage all relevant stakeholders, including patients, providers, health systems, retail pharmacies, provider-based and employer-based telehealth providers, employers, payers, device manufacturers, and academics.
- **Establish a streamlined approach to enable providers to provide Connected Care to patients across state lines.** We recommend that Congress explore state and federal proposals to address the inefficiency and costliness of multistate licensure. A framework that can more effectively enable providers to furnish telehealth services to their patients across state lines is essential to greater adoption of Connected Care.
- **Establish appropriate safeguards to ensure the delivery of medically necessary, safe, and secure Connected Care.** In defining Connected Care and putting forth a licensure framework, we recommend that Congress establish the appropriate guardrails to address concerns around the potential for the provision of medical unnecessary services and to help guarantee that Connected Care is furnished by eligible and licensed health care providers across HIPAA-compliant technologies.

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In closing, we appreciate the opportunity to submit our comments to the Subcommittee. We look forward to working with the Subcommittee as the Alliance continues its efforts to advance the adoption of Connected Care to foster a 21st century health care system that provides high quality, more efficient, and less costly care. If you have any questions, please do not hesitate to contact Krista Drobac at 202-799-4299.

Sincerely,



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