



ALLIANCE *for*
CONNECTED CARE

February 23, 2015

The Honorable Lamar Alexander
Chairman
Committee on Health, Education, Labor and Pensions
United States Senate
428 Senate Dirksen Office Building
Washington, DC 20510

The Honorable Richard M. Burr
United States Senate
217 Senate Russell Office Building
Washington, DC 20510

Dear Chairman Alexander and Senator Burr:

The Alliance for connected care (the "Alliance") commends your leadership in seeking to identify and address the challenges that are stifling innovation for healthier Americans. We believe telehealth technologies and services ("connected care") can play a critical role in modernizing our health care system and improving the quality of life for America's patients. We welcome this opportunity to offer our suggestions regarding policy and legislative changes necessary for the federal government to support the adoption of telehealth and remove 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 providers can 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 spectrum, representing insurers, retail pharmacies, technology companies, telecommunications companies, and health care entrepreneurs. The Alliance works in partnership with an Advisory Board that includes more than 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) recommendations for Congress to consider as part of its effort to align public policies to support accelerating medical innovation and patient access to care.

We recognize that our policy recommendations related to Medicare fall outside the formal jurisdiction of the Committee. We would note, however, that Medicare often serves as a benchmark for coverage and payment policies in the commercial health insurance market, as well as state Medicaid programs. We therefore offer our suggestions in support of your stated goals of identifying and removing barriers to innovation in the broader context of bipartisan and bicameral efforts to enact comprehensive legislation in the 114th Congress.

Improving Health Care Access, Quality, and Reducing Costs

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 compelling evidence to demonstrate how the benefits of connected care are improving health care access and quality, and reducing costs for payers. For example, a recent analysis by a leading actuarial consultant identified significant savings to be achieved through expanded use of connected care in the Medicare program.¹

The study examined the use of acute care telehealth services in the commercial health insurance market and concluded that replacing in-person acute care services with connected care visits reimbursed at the same rate as a doctor’s office visit could save the Medicare program an estimated \$45 per visit. The author noted that the average number of telehealth visits per patient is 1.3 visits per year, and patient issues are able to be resolved during the initial telehealth visit an average of 83 percent of the time. The most common diagnoses made during a connected care visit are sinusitis, followed by cold/flu/pertussis and urinary tract infections.

The benefits of connected care also are well-established for patients with multiple chronic conditions, which affect more than two-thirds of Medicare beneficiaries.² 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”).³ Among CHF patients, telemonitoring was significantly associated with reductions in mortality ranging from 15

¹ Dale H. Yamamoto. “Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services” (December 2014), *available at* <http://www.connectwithcare.org/studies-reports/>.

² Centers for Medicare & Medicaid Services (CMS), “Medicare Dashboard Advances ACA Goals For Chronic Conditions,” Press Release (March 28, 2013).

³ Rashid L. Bashshur, et al. “The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management,” *TELEMEDICINE AND EHEALTH* (September 2014).

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.⁴

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 levels, as compared to usual care.⁵ 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.⁶

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.⁷ 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 six 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,

⁴ 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).

⁵ 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).

⁶ 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).

⁷ 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).

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.⁸

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.⁹ 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 three percent and emergent care rates to fall from seven percent to 2.5 percent over the course of a year.¹⁰

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.¹¹ The George Washington University Medical Center conducted a study to determine the impact of a Pill Phone mobile application on medication adherence in a group of 50 randomly selected Medicaid patients.¹² 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.¹³ According to Kaiser Permanente Northern California, dermatologists have been able to diagnose and treat 80 percent of their cases through virtual encounters alone.¹⁴

The above-mentioned 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.

⁸ The Information Technology & Innovation Foundation, “Unlocking the Potential of Physician-to-Patient Telehealth Services” (May 2014).

⁹ The National Association for Home Care & Hospice, Statement to the House Energy and Commerce Subcommittee on Health (May 21, 2014).

¹⁰ *Id.*

¹¹ Congressional Budget Office, “Offsetting Effects of Prescription Drug Use on Medicare’s Spending for Medical Services” (November 2012).

¹² 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).

¹³ John S. Barbieri, et al. “The Reliability of Teledermatology to Triage Inpatient Dermatology Consultations,” *JAMA DERMATOLOGY* (February 12, 2014).

¹⁴ Robert Pearl. “Kaiser Permanente Northern California: Current Experiences with Internet, Mobile, and Video Technologies,” *HEALTH AFFAIRS* (February 2014).

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”).¹⁵ 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 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.

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.

In addition, 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

¹⁵ 42 U.S.C. § 1395m(m)(4)(C).

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.¹⁶ 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.¹⁷ 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 Medicaid coverage and reimbursement for connected care varies by state. Currently, 46 States and the District of Columbia’s Medicaid programs provide some level of reimbursement for telehealth services, and 24 states and the District of Columbia have active laws that govern private-payer telehealth reimbursement policies.¹⁸ 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 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.

Policy and Legislative Recommendations to Advance the Promise of connected care

The Alliance greatly appreciates the Committee’s efforts to advance innovation and improve care for all Americans. Our members are deeply committed to ensuring access to connected care for patients, providers and payers. To that end, we respectfully urge you to support the following proposals to achieve the promise 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 ensure that all beneficiaries can benefit from high-quality, more convenient and less costly care. To ensure a cost-effective approach, we propose a substitution requirement that would exclude a connected care visit from reimbursement if care for the same condition is provided through an in-person, face-to-face encounter within 48 hours.

¹⁶ Charles R. Doarn, et al. “Federal Efforts to Define and Advance Telehealth—A Work in Progress,” TELEMEDICINE AND E-HEALTH (May 6, 2014).

¹⁷ 42 U.S.C. § 1395m(m)(4)(F).

¹⁸ National Telehealth Policy Resource Center, Medicaid *available at* <http://telehealthpolicy.us/medicaid>.

- **Establish a standard definition of connected care.** We recommend that Congress establish a standard definition for high-quality, safe, and secure connected care that can be used across all payers.

We recommend the language in 42 U.S.C.S. § 254c-16 is very broad and a little outdated and we proposed a few modifications:

- Narrowing the scope: The language “health care, patient and professional health-related education, health administration, and public health” is too inclusive and would adversely impact the CBO score. To get around this, we suggest truncating the definition after “clinical health care.”
- “Clinical:” The word “clinical” is too limiting because there is evidence that the work of allied health professionals or other non “clinical” interaction with patients by telemedicine can lower costs. We suggest replacing “clinical” with the word “patient.”
- “Long distance” language: The words “long distance” are too limiting and don’t really fully describe what telehealth is today. We suggest using the word “remote.”

Proposed Modification: (4) Telehealth. The term "telehealth" means the use of electronic information and telecommunications technologies to support [remote] [patient] ~~clinical health care. to support long distance clinical health care, patient and professional health related education, public health, and health administration.~~

- **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 for your consideration. We look forward to working with the Committee to foster innovation in the nation’s health care system by improving quality, increasing efficiency and reducing costs. If you have any questions, please do not hesitate to contact me at (202) 415-3260.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac". The signature is written in a cursive, flowing style.

Krista Drobac, Executive Director
Alliance for connected care
<http://www.connectwithcare.org/>

cc: The Honorable Patty Murray
Ranking Member
Committee on Health, Education, Labor and Pensions