



April 1, 2019

Submitted electronically via email: telehealth.rfi@mail.house.gov

Congressional Telehealth Caucus
United States Congress
Washington, D.C., 20515

Re: Response to Congressional Telehealth Caucus' 2019 Request for Information (RFI) on the CONNECT for Health Act

Dear Members and Staff of the Congressional Telehealth Caucus:

The Alliance for Connected Care ("the Alliance") welcomes the opportunity to provide feedback on the Congressional Telehealth Caucus' ("the Caucus'") request for information (RFI) on the 116th Congress' iteration of the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act. Over the past few years, the CONNECT Act has emerged as Congress' flagship piece of telehealth and remote patient monitoring (RPM) legislation, and the Alliance appreciates being part a part of this process.

The Alliance is a 501(c)(6) organization dedicated to creating a statutory and regulatory environment in which insurers and providers can deliver, and be adequately compensated for providing safe, high-quality care using connected care technology. Our members are leading health care and technology organizations from across the spectrum, representing insurers, health systems and technology innovators. The Alliance works in partnership with an Advisory Board of more than 20 patient and provider groups, including groups representing patients with chronic disease.

As reflected in the comments below, the Alliance applauds the effort on behalf of the Caucus to continue pushing the envelope with respect to telehealth and RPM. We make specific recommendations with respect to waiving the Social Security Act's ("the Act's") 1834(m) provisions, updating provisions in Medicare Advantage and Medicaid managed care to increase access to telemedicine. The Alliance is committed to leveraging telemedicine and remote patient monitoring to improve the quality of care while also lowering costs and improving efficiency, and we believe these recommendations will serve all three of those aims.

I. Secretarial Authority to Waive Section 1834(m) Restrictions

Section 1834(m) of the Social Security Act has long been a barrier to expanding Medicare beneficiaries' access to telemedicine due to stringent originating site and geographic location restrictions. Evidence has shown that telemedicine is not only necessary in rural and underserved areas, but also in urban and suburban communities where health care may not be accessible, convenient, or affordable.

Last Congress, the CONNECT Act, as well as a bill introduced by Reps. Johnson and Matsui addressed this problem by giving the Secretary of HHS the authority to waive the restrictions. The language read:



“Sec. 2. Expanding the Use of Telehealth Through the Waiver of Certain Requirements.

“Section 1834(m) o the Social Security Act (42 U.S.C. 1395m(m)) is amended by adding at the end the following new paragraphs:

“(5) Authority to waive requirements and limitations if certain conditions met. –

- (A) In general. – In the case of telehealth services furnished on or after January 1, [2020], the Secretary may waive any restriction applicable to the coverage of telehealth services under this subsection described in subparagraph (B) with respect to certain providers of services, suppliers, provider groups, sites of care, services, conditions, individuals receiving the services, or States, as determined by the Secretary, if each of the requirements described in subparagraph (C) is met with respect to the waiver.*
- (B) Restrictions described. – For purposes of this paragraph, restrictions applicable to the coverage of telehealth services under this subsection shall include requirements relating to qualifications for an originating site under paragraph (4)(C)(ii), any geographic limitations under paragraph (4)(C)(i) (other than applicable State law requirements, including State licensure requirements), any limitation on the use of store-and-forward technologies described in paragraph (1), any limitation on the type of health care provider who may furnish such services (other than the requirement that the provider is a Medicare-enrolled provider), or any limitation on specific codes designated as telehealth services that are covered under this title pursuant to this subsection (provided such codes are clinically appropriate to furnish remotely).”*

While the language also included a condition that a cost analysis be certified by the Centers for Medicare & Medicaid Services (CMS) Chief Actuary. We learned through the process of advocating for the eTREAT Act last year that the Congressional Budget Office (CBO) did not find the language related to the CMS Actuary to be a useful guardrail. Therefore, we recommend omitting that language from the upcoming version of the CONNECT for Health legislation. We believe the elimination of the Actuary language will have no impact on the CBO score of the bill.

We urge the Caucus to make Secretarial waiver authority Title 1 and the centerpiece of the CONNECT Act. The Secretary of HHS already has authority to waive telehealth restrictions for Accountable Care Organizations, and has done so for two-sided risk models, but only after careful consideration, analysis and public comment. We believe the Secretary will take all evidence into consideration and make careful decisions that will improve access to care for seniors.

Given that CMS has already established an extensive process (Federal Register Vol1, No 220, 11/15/16) for stakeholders to seek telehealth modifiers on Part B Codes, we urge the Committee to require the Secretary to act immediately to review the merits of lifting the rural and geographic restrictions on the [101 Part B codes](#) already approved by CMS for telehealth use.

II. Condition- and Treatment-Specific Provisions Recommended for Inclusion



Secretarial waiver authority would allow HHS to develop a comprehensive approach to telehealth for seniors. However, if we have to accept an incremental course of action, which we hope we will not, below are the disease states that currently have the clearest evidence for the benefits of telemedicine.

For ease of reference, we have only listed one or two studies under each disease state. If the Caucus would like a full accounting of all of the evidence, please let us know.

a. Diabetic Retinopathy

According to the National Eye Institute within the National Institutes of Health (NIH), diabetic retinopathy, which is caused by damage to the retina associated with chronically high blood sugar, is “the most common cause of vision loss among people with diabetes and the leading cause of vision impairment and blindness among working-age adults.”¹

A January 2019 study published in the *Journal of the American Medical Association (JAMA) Ophthalmology* found that “approximately one-third of a population-based sample of U.S. adults with diabetes did not receive an annual dilated eye examination,” which is the key test for determining the onset of diabetic retinopathy. Allowing for Medicare reimbursement for primary care-based diabetic retinopathy screening would allow diabetic enrollees the opportunity to receive a dilated eye examination when they visit their primary care provider, effectively eliminating the need for a separate trip to a specialist.

The *JAMA Ophthalmology* study concluded that “the potential for primary-care based [diabetic retinopathy] screening to provide timely screening is large,” since most U.S. diabetic adults at high risk for associated retinopathy had regular contact with their primary care physicians.²

b. Heart Failure and Cardiovascular Disease

The Alliance is grateful for Congress’ inclusion of tele-stroke reimbursement in Medicare fee-for-service as part of the Bipartisan Budget Act of 2018 (P.L. 115-123). However, according to the Medicare Current Beneficiary Survey administered by the Centers for Medicare & Medicaid Services (CMS), “direct medical costs associate with heart disease (not including stroke) totaled \$281 billion in 2015 in the United States – a figure that could more than double by 2035, due to the expanding population of older Americans.”

Further, the survey found that, overall, 42.4 percent of Medicare beneficiaries had at least one heart condition, with 21 percent reporting heart rhythm problems and 7.1 percent reporting congestive heart failure. The survey notes that “[b]eneficiaries with at least one heart condition average 398 inpatient admissions per 1,000 beneficiaries, nearly three times as many inpatient admissions per

¹ “Facts About Diabetic Eye Disease.” National Eye Institute. Sept 2015.

<https://nei.nih.gov/health/diabetic/retinopathy>

² “Estimates of the Percentage of US Adults With Diabetes Who Could Be Screened for Diabetic Retinopathy in Primary Care Settings.” Gibson DM. *JAMA Ophthalmology*. 31 Jan 2019. doi:10.1001/jamaophthalmol.2018.6909



1,000 as those without (137 per 1,000 beneficiaries).” Beneficiaries with at least one heart condition also average almost double the total cost of care compared to those without.³

A technical brief of systematic reviews compiled and published by the Agency for Healthcare Research and Quality (AHRQ) in June 2016 found that three of four systematic reviews of RPM for heart failure showed lower mortality and all four of those systematic reviews demonstrated fewer heart failure-related hospital admissions.

The same technical brief showed that telemedicine used for counseling and communication in secondary prevention of cardiovascular disease (CVD) resulted in a reduction in CVD outcomes, weight, body mass index, and Framingham risk score.⁴

The Alliance encourages the Caucus to include Medicare fee-for-service reimbursement for CVD counseling and heart failure RPM as allowable uses of telehealth under section 1834(m) of the Act.

c. Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) accounted for roughly 8.5 percent of all hospitalizations among U.S. adults older than 25 during the period from 1979 to 2001. In 2010, costs attributable to having COPD were \$32.1 billion – approximately 51 percent of which Medicare paid.⁵

A 2014 literature review of robust studies with adequate sample size published by Bashshur et al. in *Telemedicine and e-Health* found that telepulmonology, which includes remote measurement of lung function and teleconsultations between primary care providers and pulmonary care specialists for the care and treatment of patients, “increased the number of patients who were not readmitted [to the hospital] (51% intervention versus 33% control), is acceptable to professionals, and involves low installation and exploitation [utilization] costs.”⁶

Telepulmonology represents a great opportunity for the Medicare program to focus on a large cohort of beneficiaries with a low-cost, high-value tool to manage symptoms and deliver care.

d. Primary Care

CMS’ Calendar Year 2019 (CY19) Medicare Physician Fee Schedule (PFS) final rule (CMS-1693-F) allowed for reimbursement of a brief, patient-initiated “virtual check-in” via telehealth in Medicare fee-for-service beginning on January 1, 2019. These short, 5-minute visits cannot be billed when a face-to-face office visit has occurred within 7 days prior or 24 hours after the virtual check-in. In our

³ “Prevalence and Health Care Expenditures among Medicare Beneficiaries Aged 65 Years and Over with Heart Conditions.” CMS. Dec 2017. <https://go.cms.gov/2V6RMrm>

⁴ “Telehealth: Mapping the Evidence for Patient Outcomes From Systematic Reviews [Internet].” AHRQ. Jun 2016. <https://www.ncbi.nlm.nih.gov/pubmed/27536752>

⁵ “COPD Costs.” CDC. 21 Feb 2018. <https://www.cdc.gov/copd/infographics/copd-costs.html>

⁶ “The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management.” Bashshur et al. *Telemedicine and e-Health*. Sept 2014. <https://bit.ly/1rcaThG>



comments to CMS during the proposed rule public comment period, we said that these check-ins will be difficult to operationalize and don't capture the value of telehealth, which is in preventing unnecessary in-person care and making follow-up care easier. However, the move to reimburse for virtual check-ins was the only way that CMS could begin to include telehealth as a modality for treatment in Medicare without violating the statutory provisions included in section 1834(m) of the Act, highlighting the need for Congressional action on this issue. The proposal was finalized, and the virtual check-ins are now included in the CBO baseline.

The Medicare program reimburses physicians about \$14.77 for each virtual check-in and the new code's economic impact was considered in the final rule. Thus, the total cost of the virtual check-in implementation has already been factored into the Medicare program's spending baseline.

Currently, office visits for established patients range from about \$22 up to \$148, depending on the severity of the condition that is being treated. The Alliance recommends that the Caucus include a provision that would allow Medicare to reimburse for telehealth visits within the 7-day/24-hour timeframe on either side of the virtual check-in in an amount that is equal to the difference between the cost of the virtual check-in and the cost of an in-person office visit.

For instance, a patient could receive a virtual check-in to receive treatment from her primary care provider on Monday for a routine sinus infection. The doctor prescribes her an antibiotic and receives \$14.77 for the visit. However, on Tuesday, the patient notices an adverse reaction to the antibiotic she was prescribed. Under the Alliance's proposal, the doctor could still get paid for time and expertise if the same patient gets another virtual consult on Tuesday. That doctor would receive \$45 for the visit under current Medicare reimbursement rates. However, the total amount of new charges to the Medicare program attributed to the follow-up virtual visit would actually be \$30.23 now that the virtual check-in is in the baseline. This figure represents the difference between \$14.77, which the provider was already paid for the virtual check-in, and \$45, which is the reimbursement rate for a Level II office visit CPT code. Since the \$14.77 virtual check-in is already calculated into the program's baseline spending estimate, Medicare could expand its virtual primary care footprint while incurring a CBO cost estimate of less than what equivalent in-person services would cost.

III. Medicaid Managed Care Provider Enrollment

In the commercial insurance and Medicare Advantage markets, telehealth is often offered by a vendor that has developed a network of trained physicians. The vendors contract with managed care entities so beneficiaries have 24/7 access to a telehealth benefit that connects them with a clinical provider. For many of these clinicians, telehealth is the sole method of practicing medicine. They are either employees or contractors to telemedicine vendors who then serve managed care beneficiaries.

The challenge is that this model doesn't work in Medicaid because of Section 5005(b)(2) of the 21st Century Cures Act ("Cures") (P.L. 114-255) which amended section 1932(d) of the Act to require "in order to participate as a provider in the network of a managed care entity that provides services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for medical assistance under the State plan under this title (or under a waiver of the plan) and who are



enrolled with the entity, the provider is enrolled consistent with section 1902(kk) with the State agency administering the State plan under this title.”⁷

This added requirement in Cures requires physicians employed by a telehealth vendor to register with individual Medicaid agencies in order to be considered “in-network” adds an unnecessary layer of administrative burden to providers and cost to the health care system.

If a telehealth vendor wanted to contract with a managed care entity to provide them with a network of clinicians that would be available to Medicaid beneficiaries, all of the clinicians working for the vendor would have to be enrolled with the state Medicaid program. Given that these providers don’t have physician practices, they aren’t enrolled in Medicaid. To make them do so would be cumbersome and costly without any obvious benefit to the patient.

These same enrollment rules were once required by Medicare, but were rolled back. CMS cannot roll back the enrollment rules for Medicaid because they are in statute. We therefore urge the Committee to change these rules so Medicaid beneficiaries may have access to the same telehealth benefits as people in Medicare and the commercial market.

IV. Medicare Advantage Enrollee Choice

The Alliance was very appreciative of Congress’ action in the Bipartisan Budget Act of 2018 (P.L. 115-123) to allow Medicare Advantage (MA) plans to include additional telehealth benefits in their basic benefit packages. The passage of this legislation represented a great step forward in expanding access to telehealth to a major portion of the Medicare population through MA.

Section 50323(a)(4)(A) and (B) of the Bipartisan Budget Act of 2018 (P.L. 115-123) stipulates that if an MA plan chooses to provide a service as an additional telehealth benefit, “the MA plan shall also provide access to such benefit through an in-person visit (and not only as an additional telehealth benefit); and an individual enrollee shall have discretion as to whether to receive such service through the in-person visit or as an additional telehealth benefit.”⁸

This provision, as it pertains to enrollee choice, would serve to limit MA plans’ ability to expand access to treatments like tele-behavioral therapy due to the requirement that the service must also be available in person. Many individuals reside in mental health professional shortage areas where it is not possible for such treatments to be furnished in person. Further, limiting the ratio of telehealth providers to in-person providers to one-to-one would only continue to restrict MA plans’ ability to offer innovative treatments beyond what is available in brick-and-mortar facilities.

The Alliance urges Congress to amend the BBA of 2018 to better align with a model law developed by the National Association of Insurance Commissioners (NAIC). Section 5 of the model law pertains to

⁷ “21st Century Cures Act.” U.S. Congress. 31 Dec 2016. <https://www.congress.gov/bill/114th-congress/house-bill/34/text>

⁸ “Bipartisan Budget Act of 2018.” U.S. Congress. 9 Feb 2018. <https://www.congress.gov/bill/115th-congress/house-bill/1892/text>



ALLIANCE *for*
CONNECTED CARE

network adequacy and states that a state insurance commissioner “shall determine sufficiency in accordance with the requirements of this section, and by establish sufficiency by reference to any reasonable criteria, which may include but shall not be limited to... other health care delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence and other ways of delivering care.”⁹ The Alliance also recommends that Congress take action to eliminate the one-to-one ratio required in the BBA of 2018 so that MA plans can better serve their enrollees using technology and resources that are available to them.

Additionally, the Medicaid managed care proposed rule (CMS-2408-P) released in November 2018 proposed to provide states with “more flexibility to set meaningful network adequacy standards using quantitative standards that can take into account new service delivery models like telehealth.”¹⁰ This new network adequacy standard would allow states the ability to more accurately frame network adequacy standards around measurements such as minimum provider-to-enrollee ratios, hours of operation requirements, a minimum percentage of contracted providers that are accepting new patients, and combinations of these measurements. For instance, allowing states to implement a standard that requires MCOs to have a specified minimum percentage of providers, including telehealth providers, who accept Medicaid can improve access to care over the current time and distance standard, which has the potential to limit the enrollees’ options with respect to accessing health care services.

Should CMS choose to finalize the provisions in the Medicaid managed care proposed rule, it would render Medicare Advantage as one of the last markets to prohibit telehealth utilization for purposes of network adequacy. This would go against the very nature of the program, which is meant to provide for a trailblazing, innovative, and efficient health insurance market under the Medicare umbrella.

The Alliance greatly appreciates the Caucus’ leadership in working to ensure that seniors are able to realize the benefits of telehealth and remote patient monitoring. We are hopeful and confident that the telehealth provisions included in the upcoming iteration of the CONNECT for Health Act will usher in a new era in virtual care.

We appreciate the opportunity to provide feedback to the Caucus and look forward to continuing to work with Congress to increase access to high quality connected care. If you have any additional questions, please do not hesitate to contact us. I can be reached at krista.drobac@connectwithcare.org.

Sincerely,

A handwritten signature in blue ink that reads "Krista Drobac".

Krista Drobac
Executive Director

⁹ “Model Law No. 74.” NAIC. Q4 2015. <https://www.naic.org/store/free/MDL-74.pdf>

¹⁰ “CMS-2408-P.” CMS. 8 Nov 2018. <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-24626.pdf>