January 28, 2016

The Honorable Orrin Hatch
Chairman
Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
219 Dirksen Senate Office Building
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The Honorable Johnny Isakson
131 Russell Senate Office Building
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Dear Senators:

We greatly appreciate your leadership to address Medicare chronic care provisions as well as your responsiveness to our earlier recommendations regarding the use of innovation and technology to improve care to Medicare beneficiaries. Attached are our comments to sections of the Bipartisan Chronic Care Working Group's policy options document.

Also, we strongly recommend to you a draft Senate bill, the Clinical Opportunities for Novel and Necessary Effective Care Technologies (CONNECT) for Health Act, with the active involvement with three Committee members. This bill and we hope the Committee's pending action address important opportunities for video, remote patient monitoring, and other telecommunications tools to improve Medicare chronic care and the delivery of other care.

Sincerely,

Jonathan D. Linkous
Chief Executive Officer

# United States Senate Committee on Finance
# Bipartisan Chronic Care Working Group
# Policy Options Document

## Receiving High Quality Care in the Home

**Expanding the Independence at Home Model of Care**

For purposes of IAH and using its transformed reimbursement incentives, the Medicare restrictions on telehealth in Social Security Act (SSA) section 1834(m) should be waived, in particular to allow a beneficiary's home to an "originating site" and to cover all beneficiaries in metro areas.

To advance the number of patients served and the demonstrated value of this model, the initial statutory restriction of 10,000 beneficiaries needs to be increased. This could be a fixed stage 2 level, such as 250,000, or to increase steadily, such as by 100,000 annually.

**Expanding Access to Home Hemodialysis Therapy**

A video visit, whether required by Medicare or medically warranted, between a dialysis patient at home and their physician should be an option for them to use.

Since existing Medicare coverage regarding dialysis patient visits with a managing physician by video means is only for rural beneficiaries, it may be necessary for purposes of Congressional Budget Office estimating to phased-in home visits starting with rural beneficiaries.

## Expanding Innovation and Technology

**Increasing Convenience for Medicare Advantage Enrollees through Telehealth**

It is important to start with how the traditional Medicare program fails beneficiaries regarding telehealth tools. There are 5 telehealth-specific restrictions in SSA section 1834(m):

1. Beneficiaries must be at a rural location
2. No asynchronous/store-and-forward uses, essentially
3. Beneficiaries need to go a designated health facility setting
4. Only selected Medicare providers are covered for telehealth services
5. Only CPT/HCPCS procedure codes are covered for telehealth

Additionally, there is the prominent omission of specific statutory coverage and reimbursement authorization for remote patient monitoring regarding chronic care.

We strongly support telehealth and remote patient monitoring services as a basic benefits under Medicare Part C. Specifically, we support legislative language under development as section 401 of the draft Senate bill, the CONNECT for Health Act.

**Providing ACOs the Ability to Expand Use of Telehealth**

We strongly support that the Medicare restrictions on telehealth in SSA 1834(m) be waived for purposes of the ACO program. In other words, Medicare payment should be made for services provided by telehealth to the extent they are otherwise covered and reimbursed by Medicare. Also, remote patient monitoring should also be available for ACOs to create value. Appropriate statutory language is in section 103(a) of the Telehealth Enhancement Act, H.R. 2066.

For purposes of Congressional Budget Office budget estimating, it may be more expeditious to enact a three-step phase-in of such flexibility with Next Generation and Track 3 ACOs in 2017, adding Track 2 in 2018, and Track 1 in 2019.

Additional safeguards about proper clinical equipment are not needed and could act as barriers to medically appropriate services. Existing statutory, regulatory, or case law safeguards, such as provider's professional judgment, professional practice rules, "standard of care" or HIPAA for patient information privacy and security, are sufficient. If any additional safeguard is proposed, it should follow the approach of Medicare's longstanding provision regarding not requiring the use of a telepresenter in SSA section 1834(m)(2)(C): "Nothing in this subsection shall be construed as requiring an eligible telehealth individual to be presented by a physician or practitioner at the originating site for the furnishing of a service via a telecommunications system, unless it is medically necessary (as determined by the physician or practitioner at the distant site)."

**Maintaining ACO Flexibility to Provide Supplemental Services**

An ACO can already use its funds for any purpose. The issue is what services should Medicare make payment.

We strongly support Medicare reimbursement of remote patient monitoring of chronic conditions for all Part B beneficiaries, whether by an ACO or fee-for-service. Specifically, we support legislative language under development as section 301 of the draft Senate bill, CONNECT for Health Act, that would improve care for all Part B beneficiaries.

For purposes of Congressional Budget Office budget estimating, it may be necessary to enact a two-step phase-in of such coverage with ACO beneficiaries in 2017 and other Part B beneficiaries in 2018. We also support another phase-in approach, section 2(d) of the Medicare Telehealth Parity Act, H.R. 2948.

Also, for purposes of Congressional Budget Office budget estimating for all Part B beneficiaries, it may be necessary to seek additional savings and innovation in three recommended ways:

- Greater hospital readmissions reduction: For achieving greater reductions in hospital readmissions, CMS should share savings with hospitals. This "carrot" would address their additional uncompensated costs for remote patient monitoring, home video visits and other hospital-provided services to achieve the greater reductions. Specifically, we recommend inclusion of section 101 of the Telehealth Enhancement Act, H.R. 2066.

- Added service scope for chronic condition payment bundles: Critical for chronic care innovation is to allow home-based remote patient monitoring and physician video visits for the bundled payment for chronic conditions, notably diabetes, congestive heart failure, chronic obstructive pulmonary disease, and cardiac arrhythmia. Section 104 of the Telehealth Enhancement Act would accomplish such improvement broadly for bundled payments.

- Enhance diabetes self-management training: This successful program should now cover the services of certified diabetes by interactive video visits. In Senate legislative language, section 3(b) of the Access to Quality Diabetes Education Act, S, 1345, is recommended. Further, preventing blindness among diabetics should be a Medicare priority and a retinal scan, whether the interpretation is provided by a remote or in-person retinal specialist, should be part of the diabetic annual exam.

**Expanding Use of Telehealth for Individuals with Stroke**

We strongly support such coverage and believe that the Congressional Budget Office could find Medicare savings from more timely use of clot-busting treatment. Specifically, we support the Furthering Access to Stroke Telemedicine Act or the FAST Act (S.1465/H.R. 2799) and such a provision included in section 105 of the Telehealth Enhancement Act, H.R. 2066.

## Identifying the Chronically Ill Population and Ways to Improve Quality

**Developing Quality Measures for Chronic Conditions**

Any such requirement should also specify measures about patient convenience and satisfaction.

## Empowering Individuals & Caregivers in Care Delivery

**Encouraging Beneficiary Use of Chronic Care Management Services**

We recommend that Part B coinsurance not apply to management services that are not a patient encounter, specifically not transitional care management or chronic care management.

**Eliminating Barriers to Care Coordination under Accountable Care Organizations**

We recommend that Medicare allow such flexibility for ACOs as supplemental benefits, discussed above.

**Expanding Access to Prediabetes Education**

Any such new coverage should allow providers, including diabetes educators, to be reimbursed when using telehealth comparable to in-person coverage.

## Other Policies to Improve Care for the Chronically Ill

**Study on Medication Synchronization**

We recommend that such a study explicitly include medication management by telehealth.