



American Telemedicine Association

1100 Connecticut Avenue, NW, Suite 540, Washington, DC 20036-4146
202.223.3333 • Fax: 202.223.2787 • www.americantelemed.org

June 22, 2015

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
Washington, DC 20510

The Honorable Johnny Isakson
131 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Mark Warner
475 Russell Senate Office Building
Washington, D.C. 20510

Dear Senators:

We greatly appreciate your interest and leadership in developing legislation for the Finance Committee on improving chronic care within your jurisdiction.

ATA signed on to a multi-stakeholder letter which concentrates on Medicare. However, we encourage you to explore the experiences, resources and opportunities with the other Social Security Act programs, notably Medicaid, State Children's Health Insurance Program, Maternal and Child Health Services Block Grant, and Block Grants to States for Social Services.

Aside from the most prevalent chronic conditions, it is important to address a broad range of other long-term illnesses or medical conditions, such as Parkinson's, multiple sclerosis, amyotrophic lateral sclerosis, cystic fibrosis, severe depression, and autism. CMS uses multiple lists of chronic conditions, just within the Medicare program.

It is important to recognize some important foundational blocks upon which to build Medicare improvements for chronic care. Pertinent to telehealth, including remote patient monitoring, and chronic care, we highlight the following:

- New and growing Medicare models with value-based payments and team-based service, such as the budget-saving Independence at Home demonstration (championed by Sen. Wyden), the increasingly attractive Medicare Advantage plans (including special needs plans focused on chronic care, accountable care organizations), bundled payments (including some bundles specifically for chronic conditions), and medical homes.
- Tougher financial penalties for hospital readmissions, notably now involving cardiac failure and, beginning in October chronic obstructive pulmonary disease (COPD).
- Newly added Medicare coverage for monthly periods of physician management for beneficiaries with "multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline."

- Medicare experience with outpatient self-management training services specifically for diabetes (section 1861(qq)).
- Increased CMS interest in coordinating Medicare and Medicaid coverage for people eligible for both – with above average incidence of either one or more chronic conditions. Georgia, New York and Virginia extend coverage of telemedicine-provided services to their dual eligible populations through the CMS Capitated Financial Alignment Model for Medicare-Medicaid Enrollees.
- Medicaid “health homes” option for chronic care, enacted as ACA section 2703, in operation in 19 states, including Alabama, Iowa, Maine, New York, Ohio and West Virginia that make some use of telehealth.
- 34 years of experience with Medicaid home and community-based services waiver programs.

We studied the states’ relevant Medicaid experience and developed a paper, *State Medicaid Best Practice - Remote Patient Monitoring and Home Video Visits* (attached) focused on chronic care.

Regarding telehealth, including remote patient monitoring, for chronic care needs, it is important to make some particular points:

- Because of their needs, traveling to a doctor’s office or clinic is often not feasible or very difficult.
- The appropriate chronic care often involves one or more specialists and they are located disproportionately in major cities.
- The tools of at-home chronic care are much less expensive than the emergency or inpatient consequences of no or inadequate care.
- The constant nature of chronic conditions makes reduced time and convenience of care highly important to beneficiaries, including their adherence.
- Distance and time to necessary care should no longer be barriers for beneficiaries.

Many payors, including private insurers and Medicaid plans, have full parity between covered services provided by telehealth and in-person means – which should be a baseline goal for Medicare and other Social Security Act programs.

Specific Recommendations

Out of sensitivity to potential CBO budget impact projections, we chose to narrow our recommendations for your initial consideration to the following:

Medicare Chronic Care Initiative

- **Independence at Home:** This successful demonstration program should 1) be expanded, including a specific waiver of the telehealth prohibition for services to a beneficiary at home and to beneficiaries in non-rural locations and 2) a date for this model to be available nationwide.

- **Remote patient monitoring:** For a beneficiary receiving chronic care management services (CPT 99490) and for an applicable condition of the readmissions reduction program, it should allow coverage for related remote patient monitoring (CPT code 99091) for the condition and related comorbidities.
- **Hospital readmissions reduction:** For greater reductions in unnecessary hospital readmissions CMS should share savings with hospitals. This “carrot” would address their additional uncompensated costs for home video visits and other instrumental services.
- **Health homes:** With a waiver of the §1834(m) telehealth restrictions, CMS should allow a state with a Medicaid “health home” project (2 or more chronic conditions) to also serve comparable Medicare beneficiaries.
- **Specialty medical homes:** With a waiver of the §1834(m) telehealth restrictions, CMS should permit a contract with entities to provide bundled and coordinated Medicare services for a specific long-term illness, chronic medical condition, or medical subspecialty.
- **Outpatient self-management training:** The diabetes program should cover the services of certified diabetes educators, at least by interactive video visits. Also, the approach used for diabetes should be extended to other chronic conditions and with parity for telehealth-provided services.
- **EHRs of value to beneficiaries:** The proposals for use of remote patient monitoring data for the stage 3 “meaningful use” payments should be strengthened, finalized, and started on schedule. Further, ONC should set short-term priorities for interoperability which include some specific tasks pertinent to improve EHR value for beneficiaries with chronic conditions, notably--
 - Patients, families and caregivers are able to use their personal devices such as smartphones, home BP cuffs, glucometers and scales to routinely contribute data to their longitudinal health records and use it or make it available to providers to support decision-making.
 - Providers have the ability to query data from other sources in support of care coordination (patient generated, other providers, etc.) regardless of geography or what network it resides in.
 - At-risk patients engage in healthcare monitoring programs which can detect life threatening situations (such as patient down and unresponsive) using at-home monitoring devices and electronic communications such as eVisits and telemedicine.

Improving Flexibility for Chronic Care Telehealth and Other Telehealth under Capitated or Prospective Payments

- **Medicare Advantage:** Revise bidding structure for plans by deeming Medicare coverage of telehealth to apply to all beneficiaries, without geographic restriction, as a standard benefit. (A plan should continue to offer additional telehealth coverage as a supplemental benefit.)
- **Accountable care organizations:** Waive restrictions of Medicare telehealth for all ACOs. At a minimum, phase-in flexibility starting with two-side risk/Track 3 plans.
- **Payment bundles for acute and post-acute episodes:** Waive restrictions of Medicare telehealth for all bundles. At a minimum, chronic condition bundles include home-based remote patient monitoring and physician video visits.
- **Home dialysis PPS:** Create parity for physician video visits between rural hospital-based and home-based dialysis. At the least, cover rural beneficiaries first and then metro-located beneficiaries.

Improving Beneficiary Access under Fee-for-service Payments

- **Telehealth for recertifications:** Allow video to comply with the recertification requirements for home health and durable medical equipment added by PPACA section 6407. The drafters seemingly intended that video visits could be a way to comply because of their reference to

1834(m), but overlooked the primary nullifying provision that a telehealth originating site cannot be a beneficiary's home. For Medicare home health patients, this is a "Catch 22" because they need to be "homebound."

- **On-line internet assessment and management:** Direct CMS to set relative value units for CPT codes 98969 and 99444.

Thank you for your leadership in this critical area affecting all Americans. We look forward to working with you to implement these improvements to the nations' healthcare programs.

Sincerely,

A handwritten signature in cursive script that reads "Jonathan D. Linkous". The signature is written in dark ink and is positioned above the typed name and title.

Jonathan D. Linkous
Chief Executive Officer