



200 First Street SW
Rochester, Minnesota 55905

January 29, 2016

The Honorable Orrin Hatch
Chairman, Committee on Finance
United States Senate
104 Hart Senate Office Building
Washington, D.C. 20510

The Honorable Ron Wyden
Ranking Member, Committee on Finance
United States Senate
107 Russell Senate Office Building
Washington, D.C. 20510

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

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

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

Thank you for the opportunity to share our recommendations with respect to how telehealth strategies can help improve quality, reduce costs and increase care coordination for beneficiaries with chronic conditions. We are writing to specifically address how the advancement of telehealth through changes in federal policy can expand the reach of medicine and knowledge, save health care costs and, most importantly, improve outcomes for patients suffering with chronic conditions.

Telehealth is improving the health of populations by expanding access to routine and specialized care, improving the experience and quality of that care, and reducing per capita costs of health care. In addition, telehealth is bridging gaps in the care continuum, as well as addressing current and future issues with respect to the supply and distribution of healthcare professionals. Across the U.S. and the globe, health care institutions, payers, and government providers have begun integrating telehealth into their practices.

As part of the largest integrated, not-for-profit medical group practice in the world, Mayo Clinic physicians see great potential to improve health and health outcomes for people in rural communities through greater use of telehealth services. In addition, because our physicians see patients from all 50 states each year, Mayo is acutely aware of the barriers existing at both the federal and state levels that inhibit the delivery of medical services through “connected care,” our term for the spectrum of telehealth platforms. Indeed, we write in our capacities as Medical and Administrative Directors of Mayo Clinic’s Center for Connected Care. Mayo uses connected care in many aspects of our practice from saving lives with our telestroke program, to enabling video consultations and remote monitoring of patients in their homes, to monitoring intensive care patients at rural facilities and across state borders, to sharing our knowledge with physicians across the country through eConsults and our AskMayoExpert program. In all of these situations, we have observed that connected care improves access, service and affordability for our patients.

Below are five policy priorities that will help advance the delivery of telehealth and work to reduce health disparities in all parts of the country, and most critically in our rural communities.

1. Lift geographic and originating site restrictions

The advantages of connected care services are not only applicable when the patient is distant or in a very remote location, but also because they can be in touch more often with more appropriate, logistically simpler methodologies than the traditional face-to-face encounter. The CMS requirement that telehealth consults be confined to authorized originating sites, such as hospitals and clinics, prevents home bound residents with chronic conditions from receiving quality home monitoring. While travel time and distance can be important factors, there are many patients in both urban and rural settings whose limited mobility makes it equally problematic to travel from home to a clinic. A patient may live in a rural area; however, the closest originating site may be in the hospital located in the nearest small city with a population of 50,000, making the visit ineligible for telehealth coverage. Medicare telehealth restrictions do not recognize the advances in technology, cost savings and patient demand for remote health care delivery –especially in our rural communities.

While CMS recently expanded coverage slightly to include rural census tracts within a Metropolitan Statistical Area (MSA), we encourage Congress to direct CMS to remove all geographic and originating site limitations, and follow the lead taken by most state Medicaid programs, which have lifted these arbitrary geographic and originating site restrictions enabling Medicare patients to receive connected care services regardless of location.

2. Better care, lower costs with remote monitoring

We encourage the committee to expand access and coverage of remote monitoring for Medicare beneficiaries. A recent Mayo randomized study, published in *Telemedicine and E-Health*, of more than 200 patients who received either additional home telehealth monitoring or the usual medical care, found that those receiving care via connected care had less variability in cost of care, lower decedents-to-survivors cost ratio, and lower total 30-day readmission cost than patients receiving traditional medical care.¹

Another study shows how remote monitoring improves patient outcomes. The 2011 report, *A Cluster-Randomized Trial of a Mobile Phone Personalized Behavioral Intervention for Blood Glucose Control*, concluded that the combination of behavioral mobile coaching with blood glucose data, lifestyle behaviors, and patient self-management individually analyzed and presented with evidence-based guidelines to providers substantially reduced glycosylated hemoglobin level over one year.²

¹ Upatising Benjavan, Wood Douglas L., Kremers Walter K., Christ Sharon L., Yih Yuehwern, Hanson Gregory J., and Takahashi Paul Y.. *Telemedicine and e-Health*. January 2015, 21(1): 3-8. Doi:10.1089/tmj.2014.0021.

² Charlene Quinn, Michelle Shardell, Michael Terrin, Eric Barr, Soshana Ballew, Ann Gruber-Baldini, *Diabetes Care*. Published Online July 25, 2011 <http://care.diabetesjournals.org/content/34/9/1934.long>.

A third study at the University of Mississippi Medical Center for Chronic Diabetes showed that remote monitoring contributed an estimated \$189 million in savings to Medicaid annually.

In addition patients are eager to see telehealth options available in managing their care. In a Mayo Clinic survey of 3,000 patients who participated in video visits, 99 percent said they would do a video visit again if their provider offered it. Satisfaction with the service was high for both providers (92 percent) and patients (96 percent).

3. Expand access to telehealth diagnosis to improve critical care

Mayo's initiative in telestroke diagnosis has shown great promise in improving patient outcomes and reducing health care costs. Researchers have found that using telehealth to deliver stroke care, also known as telestroke, not only improves patient outcomes, but is cost-effective for health care payers.

In telestroke care, the use of a secure, high definition telestroke monitor allows a patient presenting with symptoms of a stroke to be examined in real time by a neurology specialist from a remote location. The neurologist consults via computer with the emergency room physician at the patient's site, which like most rural hospitals, may not have neurology specialists. Mayo provides telestroke care by acting as a single source of specialized care – a hub – to connect a network of multiple hospitals – spokes. Many of these “spokes” are Critical Access Hospital sites that do not have the patient volumes or the financial resources to offer 24-hour access to specialized critical care.

A Mayo study estimated that compared with no network, a modeled telestroke system consisting of a single hub and seven spoke hospitals may result in the appropriate use of more clot-busting drugs, more catheter-based interventional procedures and other stroke therapies, with more stroke patients discharged home independently. Despite upfront and maintenance expenses, the entire network of hospitals realizes a greater total cost savings.

When comparing a rurally located patient receiving routine stroke care at a community hospital, a patient treated in the context of a telestroke network incurred \$1,436 fewer costs. The improvement in outcomes is associated with reduced resource use (such as inpatient rehabilitation, nursing homes, and caregiver time). Mayo Clinic Telestroke maintains hubs in Arizona, Florida, and Minnesota, and serves more than 20 health care institutions in seven states. We estimate that in Arizona alone telestroke services have saved more than 70 quality years of human life and \$5 million societal dollars since 2008. The Mayo study showed that expansion of telestroke networks across the country can improve patient-related outcomes and quality while saving overall costs, including Medicare and Medicaid funds.

Enhanced critical care remote monitoring is another example of an innovative delivery system that would improve outcomes and save health care costs if diffused more broadly. To illustrate, ICU (intensive care unit) patients in Eau Claire and La Crosse, Wisconsin, are monitored 24 hours a day, seven days a week by critical care specialists located in Rochester, Minnesota, utilizing Mayo connected care systems. Through constant surveillance, and by

providing the care teams with timely patient information, E-ICUs have been associated with a 55 percent reduction in ICU mortality and a 40 percent reduction in clinical complications.

We encourage Congress to direct the Centers for Medicare & Medicaid Services (CMS) to take advantage of this innovative care delivery by exploring alternative payment methods to more widely expand adoption of these uses of telehealth. We would be happy to provide greater detail on both the telestroke and E-ICU initiatives to the committee.

4. Expand coverage for store-and-forward or asynchronous communications

The use of secure, asynchronous (also referred to as store-and-forward) exchange of medical information effectively and economically uses telehealth technology to improve patient access and quality of care. In our outpatient clinic settings, we use this technology with our eConsults program, both within the Mayo system and with outside health organizations. This enables compliant provider-to-provider exchange of clinical information to allow subspecialty consultations to help guide diagnosis and management of more complex cases through a review of the patient's medical record, imaging studies and laboratory tests without the patient having to schedule an appointment time or go to a specific location. This saves time and the cost of scheduling visits, and improves access for other patients that require face-to-face encounters by freeing up capacity where a face-to-face visit was not warranted. Additionally, for some patients, this maximizes the care they can receive in their rural primary health care market and increases patient access to expert consultation that otherwise may be foregone if they were unable to afford additional time away or experience travel barriers to more distant facilities. Not only does this help alleviate the physician shortage in rural areas, it also saves the regional providers the costs and salary of hiring dedicated subspecialists.

5. Collaborate through medical licensure compacts

The patchwork of state-by-state medical licensing rules presents a costly and time-consuming administrative barrier to connected care services expansion both within health systems that span state lines, as well as with providers in other health systems. Presently, in order to provide medical advice via telehealth services, providers must be licensed in the state where the patient resides. While a national licensure system has been part of the widespread policy debate, the adoption of the state-by-state Medical Licensure Compact (currently adopted by 12 states) promises to be a significant improvement. In rural communities on or near state borders, a provider in a neighboring state may be more proximate to a patient than the nearest provider of the same type in their home state.

Conclusion

As advances in technology and consumer demand for telehealth options grow, government policies must keep pace with these technological and societal changes. This is important because we have seen firsthand at Mayo Clinic that telehealth provides great benefits, including greater convenience for patients and their families, safer care, better outcomes, fewer redundancies, and ultimately higher quality and cost savings for patients, providers and payers, including the Medicare and Medicaid programs. Moreover, government policies should ensure patient access to telehealth by encouraging physician-to-physician consultations and physician-to-patient services that are integrated into various care settings (clinics, hospitals, nursing homes, home health agencies, etc.). A patient's health care needs are not

defined by where they live or where they receive health care; thus, telehealth solutions enable patients and providers access to clinical expertise and care alongside the local and regional health care organization, offering wider sub-specialty care, convenience and fewer costs for the patient and his/her family. In the end, Mayo Clinic believes this will help address some of our disparities in the provision of health care services.

In addition, an important policy consideration missing from the Working Group document is the interoperability of health IT systems. Many of the policies identified by the Working Group would require health providers involved in the care of patients to transmit or receive timely and accurate information from other health providers concerning their patients with multiple chronic conditions. For example, the Working Group proposed to establish a new high-severity chronic care management code under the Physician Fee Schedule, under which health care providers would be reimbursed for coordinating care with social workers, dietitians, nurses, and behavioral health specialists. In order for such care coordination to be effective, physicians need to be able to securely send, receive and query health information electronically with these care providers and easily incorporate the information into the patient's electronic medical record. The Finance Committee should actively explore better ways to promote standards and interoperability that are inclusive of telehealth technology products and telehealth providers.

Thank you for the opportunity to address how advancing telehealth services through changes in federal health policy can improve health care for those with chronic conditions. If you have any additional questions or would like to have more information, please reach out to our federal government relations team Jennifer Mallard at 202-621-1850, mallard.jennifer@mayo.edu or Randy Schubring at 507-293-0966, schubring.randy@mayo.edu.

Sincerely,



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