January 26, 2016

Senator Orrin Hatch
Chairman
Senate Committee on Health, Education,
Labor & Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Senator Ron Wyden
Ranking Member
Senate Committee on Health, Education,
Labor & Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Senator Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

Senator Mark Warner
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators:

Thank you for the opportunity to provide recommendations to improve care for people with chronic conditions. Health IT Now (HITN) is a diverse coalition of health care providers, patient advocates, consumers, employers, and payers who support the adoption and use of health IT to improve health care and to lower costs.

Overall, HITN believes that health information technology (health IT) is integral in coordinating care, reducing costs, and improving health outcomes – especially for those with chronic conditions. However, we believe that current policies need to be reformed in order to realize the promise of health IT. To this end, we urge your consideration of policy changes that incent the use of interoperable health IT, and the expanded use of telehealth in Medicare.

Our specific comments, which may not reflect the views of individual members, are outlined below.

Telehealth

Study after study has demonstrated the benefits in use of applied telehealth, remote monitoring, and other health IT. These studies attribute reductions in hospitalizations, ER visits, length of stay, office visits, and related reductions in costs to modest investments in technology to provide care.[1] These studies add to the

[1] References to a few studies:
Case Study: Collaborative Cardiac Care Service – Collaborative Teams Improve Cardiac Care with Health Information Technology, Kaiser Permanente, available at http://xnet.kp.org/future/ahrstudy/032709cardiac.html. The study found CCCS participants were an average $60 less per day than the other group, or about $21,900 less per patient annually (Merrill, *Healthcare IT News*, 10/25).

- Electronic Medical Records and the Efficiency of Hospital Emergency Departments**,** *Med Care Res Rev,* February 2011, 68: 75-95,first published on June 16, 2010
- A study conducted by Kaiser Permanente's Institute for Health Research of more than 788,000 patient visits in eight primary care clinics of Kaiser Permanente's health care system in Colorado found that real-time physician alerts

long list of evidence supporting one of HITN's core beliefs – that the use of technology can lower costs and improve outcomes by providing the right care at the right time in the most appropriate manner.

Recognizing the potential, the VA and DoD have moved to lower cost sharing and dramatically expand the use of telehealth to not only meet the needs of returning troops and veterans, but also to lower costs. In the private sector, new technologies are being integrated directly into the acute medical benefit. For example, Aetna and Anthem are two insurers that will cover telehealth as a paid medical benefit for their employer-sponsored populations within the next two years.

Despite these facts, Medicare reimbursed $14 million for telehealth services in 2014 out of a total of approximately $615 billion, or 0.0023 percent, spent that year under the program. This disparity highlights how out-of-step the program is on its views of technology as a mode of healthcare delivery, and the amount of work needed to bring Medicare into alignment with other payers.

HITN believes that technology can deliver high quality cost-effective services to Medicare beneficiaries if such changes are made in an appropriate manner. We therefore applaud your advancing policy proposals that seek to address statutory and regulatory barriers that prevent such use.

Further, we recognize that for any telehealth proposal to work its way through Congress, it will need to promote greater quality of care delivered and be cost conscious. We therefore stand ready to be a resource and support you as you move forward with your work.

HITNs would like to specifically comment on the following policies:

1. *Expanding Access to Home Hemodialysis Therapy*

   HITN strongly supports the Working Group's proposal to expand the definition of originating site to free-standing renal dialysis facilities located in any geographical area. We also support allowing a pharmacy, retail clinic, or a patient's home as an originating site. HITN believes that any telehealth service should only be provided if standards of care are met; however, given standards of care are met, home telehealth can be beneficial to both a provider and chronic kidney disease patient because it allows medical professionals greater freedom to provide care in a way most convenient for the patient. This policy proposal accomplishes these goals.

   HITN recommends reform of the originating site fee for these new locations as one appropriate way to reduce any costs incurred as a result of your talks with the Congressional Budget Office.

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

   As the Working Group has noted, CMS does not allow Medicare Advantage plans to offer telehealth as a "basic benefit." CMS has stated that Medicare Advantage plans are subject to the

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reduced unnecessary use of a blood test used to help diagnosis blood clots in elderly patients.http://www.healthdatamanagement.com/news/study-blood-clots-tests-alerts-kaiser-41304-1.html

- Trappenburg et al. (2008), looked at remote monitoring for lung disease and found hospitalizations were reduced by 41 percent versus control.
- Finkelstein et al, (2006) found use of physiological monitoring and video visits reduced hospitalizations and nursing home admissions by 58 percent compared to control for patients with heart, lung, diabetes and chronic wounds.

same statutory restrictions as traditional Medicare as they offer Part A and B services. HITN supports efforts to revise the Part C bidding structure allow plans greater flexibility to recognize the use of new technologies when paying for care delivery.

HITN does not support applying the same restrictions to Medicare Advantage as exist under traditional Medicare. As previously stated, studies continue to show the benefit of telehealth for treating chronic conditions. A study published in September 2014 found that for three chronic conditions – congestive health failure, stroke, and chronic obstructive pulmonary disease – there were reductions in use of service, including hospital admissions/readmissions, length of hospital stay, and emergency department visits.[2]

The study also finds that it is important to allow for flexibility in telehealth benefit offerings. For example, while long-term tele-monitoring for disease management may work best for congestive heart failure, other telehealth interventions may work best for other diseases. Yet current restrictions in traditional Medicare severely limit the effectiveness of such technologies use in the delivery of care.

Given the inherent flexibility in benefit design that Medicare Advantage plans are allowed under current law, we believe that beneficiaries would benefit from applying such flexibility to the provision of telehealth services under the program.

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

HITN supports waiving for ACOs the restrictions placed on reimbursement for telehealth services under traditional Medicare. We believe that patients deserve access to the best care, regardless of location. Because many ACOs are located in metropolitan areas, it is necessary for ACOs to be able to obtain a waiver for geographic restrictions as the majority of their patients would not live in federally defined "rural" areas. Furthermore, HITN also supports the proposal that ACOs be able to obtain waivers of the originating site restriction. It is burdensome to a patient who wants to use telehealth services to require them to travel to a physician's office. Routine care and follow up visits can be done from the safety and convenience of a patient's home using interactive audio visual technology. This is less burdensome to a patient and reduces the chance of missed or rescheduled follow up appointments. For example, within the Veterans Health Administration, home telehealth services reduced bed days of care by 59 percent and hospital admissions by 35 percent. In addition, patient satisfaction with these services was 84 percent. HITN believes that Medicare can realize similar results if ACOs are able to provide telehealth services without having to meet the requirements that apply to other fee-for-service providers.

HITN also supports CMS waiving the multi-state medical licensure requirements for ACOs that serve Medicare beneficiaries in multiple states using telehealth. In order to allow for effective coordinated care, physicians who see patients across state lines using telehealth as part of an ACO or other model should not be required to also obtain additional state licenses to provide care to ACO participating beneficiaries. This would follow the model Congress authorized for Department of Defense providers who contract with the federal program to provide services to federal beneficiaries. To promote access to care and efficiency, Congress approved a singular license structure. We believe CMS should use a similar structure for the federal Medicare program

[2] Bashshur, PhD, R. (2014). The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management. Telemedicine and E-Health, 20(9), 769-800. doi:10.1089/tmj.2014.9981

in that CMS contracts with providers to deliver federal benefits to beneficiaries. Using a single license requirement would reduce costs for taxpayers and facilitate access and lower costs for beneficiaries. We believe current state licensure system presents disincentives for many physicians to use telehealth.

However, HITN does not support limiting what kind of ACOs should be eligible for telehealth waivers. HITN believes that it would be beneficial to patient care and to CMS to apply waivers to all ACOs regardless of risk structure. Telehealth has proven to save money and improve patient care, and thus should be available for use by all ACOs.

Additionally, HITN believes that the model waiver process should be reformed so that ACOs would need only apply once for a waiver of all telehealth restrictions placed on traditional Medicare, including geographic and originating site restrictions, and restrictions on store-and-forward technology. As previously stated, we also believe that multi-state ACOs should be able to waive state medical licensing restrictions for their physicians practicing telehealth across state lines. The restrictions under traditional Medicare are so broad that any ACO that wished to utilize telehealth services would likely need a waiver.

In regard to payment for services, telehealth services should not by default be reimbursed at the same level as in-person services. We believe that the use of technology in health care can lower costs, and this should be taken into consideration when developing reimbursement rates for services provided via telehealth.

4. *Maintaining Payment Model and ACO Flexibility to Provide Supplemental Services like RPM*

HITN supports the Working Group's proposal to allow ACOs to reimburse for remote patient monitoring (RPM) services. We appreciate the comment that the "clarifications would enable ACOs to spend their own resources on a broader range of services and capabilities to best serve their patient population." We believe that Congress should not place artificial restrictions on the coverage of telehealth (including remote patient monitoring) and support allowing ACOs to create remote patient monitoring plans that work best for them and their patients.

In addition, HITN believes such flexibility should be applied to all risk-bearing models under the Medicare program. When Congress passed MACRA, it intended that both the new MIPS payment system and model payment system be meaningful options for medical providers. Further, Congress envisioned that the flexibility inherent in CMS' waiver authority be used to support the use of administrative, workflow, and technological enhancements and help make such payment models viable over the long-term.

We also encourage the Working Group to carefully consider policy proposals that would extend reimbursement for RPM under traditional Medicare, as well as under new payment models created under MACRA. Under MACRA, Congress signaled its support for increasing provider and patient opportunities to use health IT in the delivery of care. However, the policy that supports such use must be carefully constructed to ensure beneficiaries are appropriately targeted for RPM services and the benefit is not abused.

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

HITN strongly supports removing geographic restrictions for all Medicare telehealth services, therefore we support the proposal to remove the restriction for stroke diagnoses. While this diagnosis is critically important to acute care, providing correct and timely treatment to a stroke patient greatly impacts what and how much chronic care is needed after a stroke occurs. Because there are often shortages of stroke neurologists in emergency departments, telestroke is essential to diagnosing and providing the correct care to stroke patients.

We also encourage the Working Group to consider additional policy proposals that take into consideration how telehealth can be best used to leverage specialty providers given growing shortages

Improving Care Management Services for Individuals with Multiple Chronic Conditions

While HITN agrees that chronic care management is critical, we are concerned with the implementation of the Chronic Care Management (CCM) code by CMS. Because of statutory and regulatory requirements, less than 20% of physicians are utilizing the code.[3] We agree with MedPAC's assessment that any new code in this area should be carefully considered so it benefits patients while not increasing burden on providers.

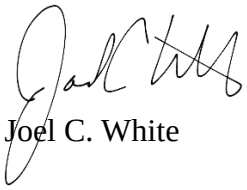
Expanding Access to Prediabetes Education

HITN supports expanding both the numbers of patients and providers eligible for diabetes self-management training. Those who are at greatest risk of developing diabetes (patients diagnosed as "prediabetic") can greatly benefit from this training to help them avoid progressing to diabetes, which increases adverse health outcomes and costs. In addition to the current proposal, we encourage the Working Group to consider how technology can be leveraged to increase the reach and efficacy of the program. We also support allowing non-Medicare providers to participate in this program, in particular diabetes educators. The sheer volume of Medicare patients who have been diagnosed as prediabetic necessitates this modification.

Conclusion

We appreciate the opportunity to share our thoughts on policy options that will allow for better chronic care coordination. We look forward to continuing to work with you on this important subject.

Sincerely,



Joel C. White

[3] http://smartlinkmobile.com/national-survey-on-medicare-cost-control-program-reveals-strong-interest-among-physicians-but-also-confusion/