



**American Hospital
Association®**

800 10th Street, NW
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100 Phone
www.aha.org

January 26, 2015

The Honorable Fred Upton
Chairman, Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Re: Telehealth Discussion Draft

Dear Chairman Upton:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and 43,000 individual members, the American Hospital Association (AHA) is pleased to provide feedback on your discussion draft of legislation on “Advancing Telehealth Opportunities in Medicare.”

Telehealth increasingly is vital to our health care delivery system. According to AHA survey data, in 2013, 52 percent of hospitals utilized telehealth and another 10 percent were beginning the process of implementing telehealth services. The AHA’s recent TrendWatch report, *The Promise of Telehealth for Hospitals, Health Systems and Their Communities* (attached), summarizes the benefits of telehealth and showcases successful hospital and health system efforts. It also speaks to barriers to greater use of telehealth.

The AHA applauds you and the other members of the Energy and Commerce Committee telehealth working group for recognizing the need to modernize Medicare’s approach to telehealth and seeking stakeholder comment on this issue. Our comments below set forth the limits of current Medicare policies, and respond to the general approach put forward in the discussion draft. The AHA looks forward to continued, and more detailed, discussions on this important topic in the coming months.

CURRENT MEDICARE POLICY

Despite recent expansions in covered services, Medicare is behind the private sector and many state Medicaid programs in promoting telehealth. For example, at least 20 states across the nation require private payers to pay the same amount for all medical services, whether delivered via telehealth or through an in-person encounter. In addition, many state Medicaid programs have more progressive policies than the Medicare program (TrendWatch, p. 8-9). Even within



Medicare, Medicare Advantage plans are beginning to provide telehealth benefits that are not covered under Medicare fee-for-service (FFS) rules, leaving the 70 percent of those utilizing FFS with limited access to these technological advances.

In order to modernize Medicare coverage and payment for telehealth, several statutory restrictions must be addressed:

- **Geographic restrictions.** By statute, Medicare will only pay for telehealth services that are provided to patients receiving care from a facility located in rural Health Professional Shortage Areas, a county that is not included in a Metropolitan Statistical Area (MSA), or in a rural Census tract. However, we know that urban areas (particularly inner cities) can also suffer physician shortages, and access to certain specialties (such as psychiatry) can be limited in all geographic areas. Further, the almost ubiquitous use of communications technology in American life today has created growing consumer expectations that, where safe and appropriate, health care services also can be accessed remotely, regardless of where the individual is located. Indeed, recent studies have shown that 74 percent of U.S consumers would use telehealth services, and 70 percent are comfortable communicating with their health care providers via text, email or video in lieu of seeing them in person (TrendWatch, p. 1).
- **Covered services.** Medicare provides coverage only for a small, defined set of services, such as consultation, office visits, pharmacological management, and individual and group diabetes self-management training services. Many of these services were listed in the authorizing legislation, while others were added by the Department of Health and Human Services (HHS). In 2015, only 75 individual service codes out of more than 10,000 physician services covered through the Medicare physician fee schedule are approved for payment when delivered via telehealth. This constrained list stands in stark contrast to the private payers operating in telehealth parity states.
- **Patient location (originating site).** Telehealth services will be covered only if the beneficiary is seen at an originating site listed in law, such as a hospital, skilled nursing facility or physician office. As our nation's telecommunications infrastructure grows, however, it will become increasingly possible to safely provide care to patients in other settings, including, potentially, the office, school or home.
- **Approved technologies.** Medicare may only cover telehealth services that are furnished via a real-time video-and-voice telecommunications system. Outside of Hawaii and Alaska, Medicare may not pay for telehealth services provided via store-and-forward technologies. And, despite growing evidence of the benefits of remote monitoring technologies for quality of care and cost savings (TrendWatch, p. 3), they are not included in Medicare's telehealth policy.

COMMENTS ON THE DISCUSSION DRAFT

The discussion draft addressed some, but not all, of the constraints noted above. While the proposed mechanism for improving Medicare's telehealth policy is a step in the right direction, we believe more needs to be done. Specifically, it calls for HHS to implement a methodology that would expand the list of telehealth services covered, and remove geographic or other restrictions for those services, but only if the Centers for Medicare & Medicaid Services actuary certifies that adding those services would not add expenses to the program. Our concerns with the approach are outlined below.

Medicare already deploys a service-by-service consideration for telehealth that results in a "positive list" of covered services. It has proven to be a cumbersome approach that results in limited coverage. Given the rate of change in technology, and particularly in the use of technology in health care, a more nimble approach would be preferred. For example, other aspects of Medicare policy, such as payment for services delivered in ambulatory surgical centers, use a "negative list" that identifies those things that cannot safely be delivered in that setting and will not be covered.

In addition, removing geographic and other restrictions only for certain services creates real operational challenges. For example, it would be very challenging to establish a telehealth program to address access problems in the inner city if only certain services are covered. This approach also could be very confusing for Medicare beneficiaries. Why would they be able to benefit from the convenience of telehealth for one service, but not another?

Unfortunately, the proposal does not address the technology limitations of the current Medicare program. It does not address payment for remote monitoring, which is increasingly common and is demonstrated to provide significant benefits for patients. For example, Geisinger Health Plan (GHP) implemented a remote monitoring program for individuals at risk of heart failure, which led to significant reductions in admissions, readmissions and cost of care (TrendWatch, p. 10).

We also are concerned that the requirement for the Medicare actuary to certify telehealth cost neutrality for specific services would be hard for HHS to operationalize, and would add a time-consuming step when technology is advancing at a rapid pace. There is a growing body of evidence that telehealth improves care and saves money (TrendWatch, p. 4-5). Indeed, a recent actuarial study based on actual experience in the private sector projects significant savings for Medicare if it expanded reimbursement (Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services by Dale Yamamoto, December 2014; www.connectwithcare.org).

Finally, we support the section of the discussion draft that encourages the provision of telehealth services in demonstration projects and models under the Center for Medicare and Medicaid Innovation (CMMI) by waiving the current limitations on what qualifies to be an originating site and the geographic location of such sites, as well as the type of provider who may furnish telehealth services. However, it should be made clear that the providers of telehealth services under CMMI demonstration projects and models should be adequately reimbursed for provision of those services.

The Honorable Fred Upton
January 26, 2015
Page 4 of 4

In conclusion, the AHA strongly agrees with your goal of expanding coverage of telehealth services in Medicare, and appreciates the specification of a mechanism for doing so. However, given the growing body of evidence that telehealth increases quality, improves patient satisfaction and reduces costs, we believe a more global approach to expanding Medicare coverage of telehealth is warranted. The AHA greatly appreciates the opportunity to provide input and looks forward to continued discussion of this important policy issue.

If you have any questions or need further information, please contact Kristina Weger (202) 626-2369 or kweger@aha.org.

Sincerely,

/s/

Rick Pollack
Executive Vice President