



**American Telemedicine Association**

1100 Connecticut Avenue, NW, Suite 540, Washington, DC 20036-4146  
202.223.3333 • Fax: 202.223.2787 • [www.americantelemed.org](http://www.americantelemed.org)

January, 26, 2015

Dear Telehealth Workgroup:

We greatly appreciate your deep interest in telehealth and persistent collaboration to extend federal support for its use to improve quality, reduce cost and extend access to healthcare.

Your early draft establishes significant changes in the near-term for Medicare and its beneficiaries regarding telehealth. This represents a milestone in enabling providers to use telehealth tools. After reviewing the draft we offer a number of suggestions which we believe will strengthen the proposal and enhance its potential for passage in the House and Senate.

Delegation to the Centers for Medicare and Medicaid Services

The proposed primary approach appears attractive and is surely designed to attract support from the administration, or at least reduce any significant objections. However, we have a major concern about the prospect of actual success.

History does not support optimism about such an approach. Over the last 20 years the telehealth community has been teased several times into believing that Medicare would soon treat telehealth provided services comparable to in-person services only to have such interests flounder or later be withdrawn. On numerous occasions CMS has refused to budge when given bipartisan directives from Congress. For example, CMS has never begun to undertake the work to even report to Congress on improving coverage of telehealth as directed in BIPA 2000, Section 223. In addition, CMS is probably not ready or willing to do what is necessary to deliver change on its own. For example, despite being funded over \$10 billion to foster change in the way healthcare is delivered, the Center for Medicare and Medicaid Innovation, has done little to demonstrate telehealth applications, especially in innovative payment models that will be needed to meet the “no net spending increase requirement” of the proposed approach. Finally, CMS has rejected using telehealth by Accountable Care Organizations and the bundled payments initiatives. The reality is that almost every improvement in Medicare coverage of telehealth has only been after Congress has enacted change, over the objections of CMS.

An alternative approach might be for Congress to create a multi-year sequence of steps to reduce the statutory barriers to telehealth and to give CMS a “negative option” to assure that a specific expansion would not result in a net spending increase. Therefore, for relying on CMS to work, we recommend some intermediate steps for their action, such as requiring the BIPA section 223 report by January 19, 2017 (before a new Administration begins). We also recommend advisory roles for the Medicare Payment Advisory Commission and the Government Accountability Office. For example, MedPAC could report by December 2017 the utilization and spending for

Medicare telehealth, including by most common procedure codes, and GAO could review relevant Medicaid experience and identify lessons for Medicare.

### Certification of No Budget Impact

We understand the present political requirement that proposals must not cause a net increase to Medicare spending and do not object to the inclusion of some form of it. However, we are concerned that the no spending increase test and process of certifying could be too rigorous to ever be conclusive and result in an endless economic debate and no action. Further, studies have shown that, although there are significant savings that can be achieved from the use of telehealth, such savings have historically taken greater than 12 months to be realized. As an alternative, we suggest that the one year period proposed on page 2, line 17 be extended 2-3 years.

A problem arises by delegating this decision to CMS. Administrative agencies often treat such authority as an opportunity for delay or inaction. A good example from outside telehealth of the difficulty of both Administration action and budget constraint is the matter of the 3-day prior hospitalization requirement for a Medicare-covered SNF stay. Over 30 years ago Congress gave the Secretary in section 1812(f) the authority to modify the requirement, in part or in whole, and the rigid requirement still is a barrier.

You might also consider alternative means, such as to create a role for Congress's Medicare Payment Advisory Commission in certifying that any use of telehealth generates no additional costs or offsetting savings.

### Specific Proposals for Addition in Medicare or Medicaid

The work of this group provides a historic opportunity that will allow medical providers to use new tools to improve and transform the delivery of healthcare. It is important for the health care of Medicare's beneficiaries and the future of the Medicare program that Congress try to enact as much as possible as soon as possible and provide a strong example to CMS.

To ensure such passage, it is important for the Committee to seek budget estimates from CBO on some proposals that may either save not increase federal spending. Appearing below are a few proposals that can meet such a goal. For these new telehealth benefits, we are prepared to accept that the existing "originating site facility fee" not apply.

#### **1. Accountable care organizations and bundled episodic payments**

Allowing the use of telehealth without the restrictions of 1834(m) for these two payment innovations are the most strategically important and popular steps for Congressional action. This one action could serve to advance a number of parallel proposals such as many of the provisions in H.R. 3306 and 5380. We strongly recommend inclusion of the language from the recent H.R. 3306 sections 103 and 104.

If necessary for CBO, year 1 could be limited to two-sided risk ACOs and extend for year 2 all of the other participants.

## **2. Medicaid telehealth networks for high risk pregnancies and births**

We have the best data to support budget savings for the provision from H.R. 3306 section 201. Independent CBO-style analysis estimated savings of \$186 million over 10 years.

## **3. Timely diagnosis of stroke**

The potential savings data from avoided post-acute care compiled by the American Heart Association/American Stroke Association is compelling. We recommend legislative language from H.R. 3306 section 105(a)(1).

## **4. Telehealth services to enable home kidney dialysis**

If necessary for CBO, year 1 could start for beneficiaries already meeting the rural geographic requirement and extend for year 2 to all metropolitan beneficiaries. We recommend legislative language from H.R. 3306 section 105.

## **5. Remote patient monitoring for CHF/COPD**

For remote patient monitoring of chronic conditions, we recommend starting 1) with two conditions targeted for hospital readmissions reduction: congestive heart failure and chronic obstructive pulmonary (beginning in October), 2) paying for CPT code 99091 for the monitoring services, 3) when in conjunction with chronic care management (CPT 99490), and for a period of up to 90 days. It may be necessary for the Committee to add such coverage in year 2, building on the experience of ACOs and the payment bundles for CHF and COPD. We can draft the legislative language.

## **6. FQHCs**

Since rural FQHCs are already telehealth patient sites and Medicare pays for FQHCs with a special prospective payment system, it would be a useful intermediate directive to CMS to, not later than 2 years after the date of enactment, make any necessary payment methodology adjustments for video visits to metro centers and for store-and-forward services to rural centers.

## **7. Add CPT codes for telehealth coverage**

In section 1834(m)(4)(F)(i), specify coverage for the following CPT codes:

- 96118-96119 neuropsychological testing
- 99238-99239, hospital discharge services
- 99291-99292, critical care and evaluation
- 99315-99316, nursing facility discharge services
- 99318, other nursing facility services

## **8. Set RVUs for on-line internet assessment and management**

CPT codes 98969 and 99444

## **9. Allow telehealth for recertifications**

Fix a “catch 22” Medicare recertification requirement by allowing home-based video to be used for beneficiaries and physicians to comply with the recertification requirements for home health and durable medical equipment for Medicare and Medicaid imposed by the Affordable Care Act section 6407. The drafters seemingly intended that video visits could be a way to comply because of their reference to 1834(m), but overlooking the 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 “homebound.” Of course, this drafting problem also adversely affects home health agencies and DME suppliers. The legislative remedy would be to amend both the home health and DME provisions so they would be without regard to 1834(m)(2)(B) [originating site fee] and (4)(C) [originating site restrictions].

### Specific Proposals Amending Other Acts

## **10. Medical board compacts**

The proposed sense of Congress provision should be amended on page 9, line 24 by inserting the word “reciprocal” before “State medical board compacts.” This aligns the proposal with previous Congressional action for DOD and ensures seamless and more cost-efficient implementation. There would be cost savings for federal agencies that currently pay for multiple state medical licenses for employees.

## **11. Consolidate funding for 4 categorical grant programs for the HRSA Office for the Advancement of Telehealth.**

This would cover the categorical programs, under CFDA 93.211, are for telehealth networks (42 USC 254-14(d)(1)), telehealth resource centers (42 USC 254-14(d)(2)), licensure portability (42 USC 254-18), and evidence-based tele-emergency networks. This can result in significant efficiencies through program coordination.

## **12. Autism CARES Act networks**

Amend Section 399BB of the Public Health Service Act (42 U.S.C. 280i-1) in subsection (b) by inserting “(7) promote the creation of a network of autism care centers to improve care quality and accessibility.”

## **13. Expand eligible providers for the FCC’s Universal Service Support**

Add H.R. 3306 section 301 provision for--

- Ambulance providers and other emergency medical transport providers.
- Health clinics at elementary and secondary schools as well as post-secondary educational institutions.

- Any other Medicare or Medicaid telehealth site.

Sincerely,

A handwritten signature in blue ink, reading "Jonathan D. Linkous", is centered on a light blue rectangular background. The signature is written in a cursive, flowing style.

Jonathan D. Linkous  
Chief Executive Officer