



American Telemedicine Association
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Ms. Amy Bassano
Acting Deputy Administrator for Innovation and Quality &
Acting Director of the Center for Medicare and Medicaid Innovation
U.S. Department of Health and Human Services
Center for Medicare and Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

RE: Center for Medicare and Medicaid Innovation New Direction

Dear Ms. Bassano:

The American Telemedicine Association (ATA) appreciates the opportunity to respond to the Center for Medicare and Medicaid Innovation's request for information.

The Medicare and Medicaid programs have explored improving care, lowering costs, and better aligning payment incentives to support patient-centered practices. However, major healthcare delivery problems persist: barriers of time and distance; professional shortages; rising costs, disparities in access; maldistribution in healthcare resources; induced volume; fragmented care; and lack of consumer choice and convenience.

Telehealth is structured to be patient-centered and anywhere, anytime. Now is a good time for CMS to fully explore consumer-directed, technology-enabled, site-neutral tools of care to meet growing healthcare delivery challenges. Telemedicine tools ensure timely, patient-focused and cost-effective access to an array of healthcare services from qualified health professionals across the entire spectrum of care.

Across the country, telemedicine is used in many forms by patients, hospitals, health systems, specialists, home and community-based providers, and federal programs servicing active and retired military.¹ It can take many forms using popular consumer devices such as personal computers, smartphones and tablets, and may be supported by digital diagnostic device peripherals including an otoscope, pulse oximeter, glucometer, stethoscope, scale, and blood pressure cuff. Prime examples of telehealth's value are uses that include access to highly specialized physicians and other health services 24 hours a day/7 days a week, and the accommodation of patient choice and preferences such as language or gender. These services include but are not limited to high volume specialists, preventive services, mental health, substance abuse, urgent care, and routine primary care.

ATA is encouraged by the CMS approach outlined in the RFI and sees opportunities for the Innovation Center to measure the impact of new models on the following indicators: expanded access, healthcare service wait times, triage, screening, patient satisfaction, travel time and distance, medical transport use, care coordination, patient adherence to care plan, and cost savings. We encourage the Innovation Center to use the following tenets to structure new model designs:

Build on Medicaid Progress

All 50 states have some coverage for telemedicine-provided services in their Medicaid plans.² Further, federal Medicaid law is unrestrictive about telehealth coverage, in contrast to Medicare law that does more to restrict than cover. Thus, almost every state Medicaid plan is better than Medicare covering telehealth and has more experience.

At this time, ATA believes the fastest, easiest way to improve Medicare telehealth is to allow states to develop and operate combined and coordinated Medicare and Medicaid telehealth. This approach has the added value of allowing the Medicaid plans to use economies of scale and broaden inadequate coverage.³ One specific opportunity is to allow a state to use its Medicaid “health home” project for chronic care to serve Medicare beneficiaries as well.

Build on Medicare Payment Innovations

Utilizing telehealth is essential for CMS and contracted health plans to innovate the delivery of care and create new service models that improve the quality of all care. ATA believes it is important to provide the agency and payors more ability to leverage data to employ network design strategies to reduce cost, promote good health outcomes, and improve quality and enrollee health. These strategies can include waiving co-pays for telehealth-enabled primary care and behavioral health services, offer bundled payments for telehealth-enabled episodes of care, and permitting telehealth providers to bid on the payment amount.^{4, 5}

Two specific value-based payment arrangements that can quickly be enhanced are Next Generation accountable care organizations and bundled payments for episodes of post-hospital care. For these ACA initiatives, all of the statutory fee-for-service style restrictions on telehealth should be waived, notably about an originating site, a provider’s service to the extent of Medicare’s in-person coverage, and asynchronous/store-and-forward services.

Broaden Multi-Disciplinary Specialty and Integrated Service Models

Integrated service delivery can benefit hospitals, health systems, community health centers, and solo/group practitioners, make better use of their time and resources and offer greater value to their patients, including health outcomes and adherence to care plans. Additionally, leveraging the clinical expertise of advanced practice registered nurses and physician assistants can significantly alleviate the burdens of workforce shortages and inadequate healthcare access. Possible models for further exploration include children with complex

medical needs; substance abuse treatment; depression; primary care and behavioral health; oncology and behavioral health; and stroke and post-acute rehabilitative services.^{6, 7, 8}

Improve Access by Enhancing Existing and Creating New Points of Care

Telehealth is an important part of the delivery of integrated care, prevention, and ongoing treatment and can be practiced with the assurance of quality and safety for the public, allowing many services to be delivered to anyone anywhere including a residence, school, daycare, community health center, or retail health clinic. Research shows that patients receiving such care are more likely to have better health outcomes, decreased school absenteeism, and less likely to be admitted (or readmitted) to the hospital, resulting in significant cost savings.^{9, 10, 11, 12, 13}

Allow Technology Neutrality

In particular, CMMI should explore waiving Medicare's restriction on asynchronous uses, such as for diabetic retinopathy or wound management. This allows for broader application of new models with the consideration for the patient's circumstances, the provider's specialty, and/or the intended use for the clinical or personal information obtained from the tool.

Furthermore, CMMI should explore reimbursing for online evaluation and management services provided by a physician to an established patient, guardian or health care provider not originating from a related E/M service provided within the previous 7 days (CPT code 99444). Online care has grown in popularity in all age groups as a convenient, low-cost, and safe and effective way to obtain health care services from their providers during times outside typical office hours, time from request to appointment exceeds three days, and when non-urgent conditions present during times when high cost access points such as emergency departments are the only care options.

Increase Patient Choice and Provider Competition

Patients should be able to choose how they receive a covered service, including considerations for their urgency, convenience and satisfaction. Many people have a difficult time accessing in-person healthcare due to mobility limitations, scheduling, appropriate provider availability, major distance or time barriers, and transportation limitations (lack of a car or public transit). Telehealth enables this vulnerable population to receive critical and life-saving treatment regardless of economic means, physical ability, or residence.

To accommodate dynamic clinical models and patient preferences for 24/7/365 and on-demand access to care, large healthcare systems have responded to this need for more accessible care by establishing provider networks across multiple states.

To test and implement a successful consumer-driven model, the Innovation Center should allow persons receiving a Medicare, Medicaid, or CHIP funded health service access to licensed health professionals without requiring that professional to have more than one state

license. Other federal interstate healthcare, notably the Department of Defense, follows a “one state license” model as an option of federal sovereignty.

Thank you for your consideration of these recommendations. We are happy to be a resource to you and your staff as you make advances to redirect the Innovation Center’s resources and actions.

Sincerely,



Sabrina L. Smith, DrHA
Interim Chief Executive Officer

¹ Herman, Bob. Virtual Reality: More Insurers are Embracing Telehealth. Modern Healthcare. February 20, 2016. <http://www.modernhealthcare.com/article/20160220/MAGAZINE/302209980>

² L. Thomas and G. Capistrant. February 2017. State Telemedicine Gaps Analysis: Coverage & Reimbursement.

³ Towey, M. (2012). Speech Therapy Telepractice for Vocal Cord Dysfunction (VCD): MaineCare (Medicaid) Cost Savings. International Journal of Telerehabilitation, 4(1), 37-40. doi:<https://doi.org/10.5195/ijt.2012.6095>

⁴ Zak, A. (2015 March). Doctors want to be paid to talk to patients online as more health systems adopt telemedicine. Retrieved from <https://www.bizjournals.com/seattle/blog/health-care-inc/2015/03/doctors-want-to-be-paid-to-talk-to-patients-online.html>.

⁵ Russo, Jack E., et al. VA Telemedicine: An Analysis of Cost and Time Savings. Telemedicine and e-Health 22:3 (2016). http://online.liebertpub.com/doi/abs/10.1089/tmj.2015.0055#utm_source=ETOC&utm_medium=email&utm_campaign=tmj

⁶ Copeland, J and Martin, G. (2004) Web-based interventions for substance use disorders: A qualitative review. Journal of Substance Abuse Treatment, 26(2), 109-116.

⁷ Frueh, B., Henderson, S., and Myri, H. (2005). Telehealth service delivery for persons with alcoholism. Journal of Telemedicine and Telecare, 11, 372-375.

⁸ Linda Godleski, M.D., Adam Darkins, M.D., M.P.H., John Peters, M.S. Outcomes of 98,609 U.S. Department of Veterans Affairs Patients Enrolled in Telemental Health Services, 2006–2010. Psychiatric Services 2012; 63(4): 383–385.

⁹ Baker LC, Johnson SJ, Macaulay D, and Birnbaum H. Strategies To Cut Costs: Integrated Telehealth And Care Management Program For Medicare Beneficiaries With Chronic Disease Linked To Savings. Health Affairs. September 2011; 30(9):1689-1697.

¹⁰ Medicaid HCBS/FE Home Telehealth Pilot Report, Kansas Health Institute, 2010. (http://media.khi.org/news/documents/2011/04/26/Telehealth_evaluation.pdf)

¹¹ McConnochie KM, Wood NE, Herendeen NE, ten Hoopen CB, and Roghmann KJ. Telemedicine and e-Health. June 2010, 16(5): 533-542. doi:10.1089/tmj.2009.0138.

¹² Federal Briefing Document: Home Telehealth: Enhancing Care, Saving Costs, Home Care Association of New York State, March 23, 2012. (<http://www.hca-nys.org/TelehealthBriefingDoc.pdf>)

¹³ Mangan, Dan. CVS Teams with Telehealth Trio to Boost Access to MD Care. CNBC. August 26, 2015. <http://www.cnbc.com/2015/08/26/cvs-signs-deal-with-telehealth-companies-for-sixstates.Html>