AMERICAN TELEMEDICINE ASSOCIATION
1100 Connecticut Avenue, NW, Suite 540, Washington, DC 20036-4146
202.223.3333 • Fax: 202.223.2787 • www.americantelemed.org

March 4, 2014

Secretary Kathleen Sebelius
Department of Health and Human Services
200 Independence Avenue S.W.
Washington, D.C., 20201

Dear Secretary Sebelius:

We write to urge you to make scalable improvements in policies affecting the use of telehealth in alternative payment models. Medicare providers paid under alternative payment methods should have the flexibility to use telehealth as a means to add value for Medicare and its beneficiaries. This would be comparable to the telehealth flexibility for Medicare Advantage plans under Social Security Act section 1852(a)(3)(A).

Specifically, we request that you waive the Medicare restrictions on telehealth in section 1834(m)--

1. for accountable care organizations (ACOs) using your authority under section 1895(f) and
2. for Center for Medicare and Medicaid Innovation payment models for bundled acute care and medical homes using your authority under section 1115A(d)(1).

Also, we request that you waive section 1895(e)(1) for ACOs, bundled payments, and medical homes to allow home telehealth and remote monitoring for "homebound," section 1895 beneficiaries.

Telehealth should be an integral part of health care delivery reform under value-based alternative payment methods. The benefits of telehealth for Medicare beneficiaries and the Medicare program include:

- A reduction of in-person overuse, such as in emergency rooms and preventable inpatient admissions
- Improved triage for faster, appropriate specialist care
- Improved patient outcomes and quality
- Increased provider productivity
- Decreased provider shortages
- A reduction in disparities to patient access
- Decreased unnecessary variations in care
- Improved support care coordination and population health
- Sustained federal investment in EHR/HIE, broadband, and telehealth infrastructure
- A response to beneficiary preference for convenience and satisfaction

It is important to increase the use of Medicare alternatives to fee-for-service reimbursement. One way to attract participation in those alternatives, especially "two-sided risk" methods, is to

give them advantages over fee-for-service arrangements. One such advantage should be the availability of telehealth means. Telehealth is also a useful tool for meeting the financial objectives of these alternatives – and improving beneficiaries' satisfaction.

There is bipartisan interest in Congress for such reasonable and useful improvements. H.R. 3306 includes a statutory change for Medicare's restrictions on telehealth to not apply to all ACOs and bundled payments (under sections 103 and 104, respectively). Also, the SGR reform agreement includes a provision for the Medicare restrictions to not apply to a forthcoming "alternative payment method" program (under section 2(e)(5) of S. 2000 / H.R. 4015).

The explicit Medicare restrictions on telehealth in 1834(m) are—

- No coverage for about 80% of Medicare beneficiaries who happen to live in the about 1200 metropolitan counties.
- No coverage for "store-and-forward" services (such as transmission of medical images) for the 43 million beneficiaries who live outside of Alaska and Hawaii.
- No coverage for services originating from a beneficiary's home (even for the "homebound"), a hospice and anywhere else from which a beneficiary seeks service.
- No coverage for otherwise covered Medicare services of physical therapy, occupational therapy, speech-language pathology, audiology and some other practitioners.
- No coverage for most health procedure codes, precluding the best judgment of physicians and other practitioners about the medical needs and other circumstances of all Medicare beneficiaries.

Furthermore, there is no permanent coverage in fee-for-service Medicare for remote monitoring of beneficiaries with major, and often multiple, chronic conditions. In particular, home health providers are barred under section 1895(e)(1) from cost-effective uses of telehealth. Under value-based alternative payment methods, providers should be allowed remote patient monitoring and home-based video conferencing services in connection with the provision of home health services (under conditions for which payment for such services would not be made under section 1895 for such services) in a manner that is financially equivalent to the furnishing of a home health visit.

There has been accelerating action among the states to take advantage of telehealth advances, including providing full parity with in-person service coverage. Importantly, CMS has the experience of many state Medicaid plans that are better than Medicare on using telehealth.

Of course, we would welcome the opportunity to work with you and your designees on such timely actions.

Sincerely,

Jonathan D. Linkous
Chief Executive Officer