American Hospital Association®

Statement

of the

American Hospital Association

before the

Communications, Technology, Innovation and the Internet Subcommittee

of the

Committee on Commerce, Science, and Transportation

of the

U.S. Senate

"Advancing Telehealth through Connectivity"

May 1, 2015

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment for the record in support of advancing the use of telehealth to improve access to health care services.

Telehealth increasingly is vital to our health care delivery system, enabling health care providers to connect with patients and consulting practitioners across vast distances. Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes, and less expensive and more convenient care options for patients. According to AHA survey data, in 2013, 52 percent of hospitals used telehealth and another 10 percent were beginning the process of implementing telehealth services.[i]

Telehealth offers significant promise for health care patients and providers, yet significant barriers to expansion remain, greatly limiting health care access for many patients. **The AHA applauds the committee for its interest in advancing the use of telemedicine, and we look forward to working with its members to achieve that goal.** Below we outline the different types of telehealth modalities, examples of how telehealth is used to provide care and, finally, current obstacles and proposed solutions for the committee to consider as it develops legislation. **We specifically urge the committee to consider the limitations of Medicare payment on services delivered via telehealth and expand support for broadband access for**

health care providers under the Health Care Connect Fund administered by the Federal Communications Commission (FCC).

THE THREE TRADITIONAL MODALITIES OF TELEHEALTH

Telehealth traditionally encompasses three main modalities, each with distinct applications within the broader telehealth industry.

One telehealth modality is "**real-time**," a live, two-way interaction between a patient (or the patient's caregiver) and a health care provider using audiovisual technology. Real-time telehealth services can be used to consult, diagnose and treat patients.

Another telehealth modality is "**store-and-forward**," which involves the transmission of a patient's recorded health history (e.g., pre-recorded videos or digital images such as X-rays and photos) through a secure electronic communications system to a health care provider, usually a specialist. The information is used to evaluate a patient's case or, in some cases, render a service outside of a real-time interaction. Store-and-forward technologies have the advantage of providing access to patient data after it has been collected, and are particularly beneficial to patients requiring specialty care when providers are not otherwise available locally.

A third telehealth modality, "**remote patient monitoring**," involves collection of a patient's personal health and medical data via electronic communication technologies. Once collected, the data is transmitted to a health care provider at a different location, allowing the provider to continue tracking the patient's data once the patient has been released to his or her home or another care facility.

In addition to these traditional telehealth modalities, a growing number of mobile health, or "**mHealth**" technologies, applications and online services are being sold directly to patients, such as wearable devices to track health and wellness. The market for wearable devices is expected to increase from $1.5 billion in 2014 to $6 billion by 2016. [ii] Patients will be able to benefit from tools such as wearable electrocardiogram (EKG) monitors, which deliver readings to a treating physician.[iii]

Increasingly, information from these devices and applications will become linked to the health information managed by providers. For example, Apple is marketing its Health app to patients, allowing them to aggregate personal health information on their Apple devices and link those data to mobile health applications that work with the Apple platform through *HealthKit*. At the same time, Apple is partnering with providers and electronic health record (EHR) companies to determine how the tool can be used in health care settings.

Similarly, mobile platforms, such as smartphones, will likely become a more significant part of the telehealth platform over time.[iv] Easy access to smartphones, tablets and other devices is a critical component enabling patients to more fully embrace mHealth applications. Between 2011 and 2016, the number of Americans with smartphones is expected to grow two-fold from 93.1 million to 192.4 million.[v]

APPLICATIONS OF TELEHEALTH BY HOSPITALS AND HEALTH SYSTEMS

Hospitals can provide the base from which telehealth services are offered, thereby expanding access to care for a wider population. Some examples of hospital-based platforms include telestroke, tele-ICU, cybersurgery and remote monitoring.

Improving Access to Health Care and Convenience for Patients
Approximately 20 percent of Americans live in rural areas where many do not have easy access to primary care or specialist services. Patients in urban areas also face challenges due to physician shortages. The availability of telehealth services to these areas facilitates greater access to care by eliminating the need to travel long distances to see a qualified health care provider. Telehealth also can fill gaps in subspecialist care. Telepharmacy is another way to offer patients the convenience of remote drug therapy monitoring, authorization for prescriptions, patient counseling and monitoring patients' compliance with prescriptions. With a nationwide shortage of psychiatrists, telepsychiatry allows psychiatrists to use videoconferencing to speak to and evaluate patients in need of mental health services, who may otherwise have to drive hours to see mental health providers.

Rural and critical access hospitals (CAHs) often are in need of critical care clinicians to diagnose, manage, stabilize and make transfer decisions concerning their most complex patients, and can use telehealth to connect to those services. Telestroke programs can expedite delivery of time-sensitive treatments to patients who present to emergency rooms that lack needed specialists, saving lives and reducing the adverse consequences of stroke. Tele-ICU programs can help hospitals supplement clinician staffing of their ICU beds.

In addition to improving access, patients are increasingly expecting levels of convenience in health care similar to what is available in the retail and banking sectors.[vi] Telehealth, regardless of geographic location, can foster a patient's ability to connect with a primary care physician or health system on a more flexible basis and often without an in-person visit. Patients are able to receive services at a distance by using secure online video services or through secure email, often with the added benefit of reducing travel to health care facilities.

Improving Quality of Care and Patient Satisfaction
There is a growing body of research illustrating that the use of telehealth can significantly improve the quality of patient care. Research conducted in 2013 on nearly 120,000 adult patients from 56 ICUs in 32 hospitals belonging to 19 U.S. health-care systems concluded that ICU telehealth interventions, especially those that increase early intensivist case involvement, improve adherence to ICU best practices, reduce response times to alarms and encourage the use of performance data. In addition, the overall effects of ICU telemedicine programs were associated with better survival rates for patients and reduced hospital lengths of stay. [vii] Significant improvements in the quality of care for seriously ill and injured children treated in remote rural EDs also were achieved by using telehealth consultations with pediatric critical care medicine physicians at the University of California, Davis Children's Hospital. [viii]

For several years, the Veterans Health Administration (VHA) has used telehealth for home health monitoring to track vital signs and conditions for patients with chronic diseases or who

have been released recently from the hospital. Adam Darkins, former chief consultant for telehealth services for the VHA, reported that telehealth services in its post-cardiac arrest care program resulted in a 51 percent reduction in hospital readmissions for heart failure and a 44 percent reduction in readmission for other illnesses. In addition to improved patient care, veterans reported patient satisfaction levels of 84 percent for the home telehealth services provided through the program. VHA's Clinical Video services with real-time video conferencing between VA medical centers and VA Community Based Outpatient Clinics also were rated highly, with a 94 percent patient satisfaction rate. [ix]

BARRIERS TO EXPANDING TELEHEALTH SERVICES

Coverage and Payment for Telehealth Services

Few obstacles present greater challenges for providers seeking to improve patient care through telehealth technologies than coverage and payment for telehealth services. Whether providers are adequately reimbursed for telehealth services is a complex and evolving issue and, as a result, a possible barrier to adopting such services.

A baseline question with respect to provider payment for telehealth services is whether the payer covers telehealth services at all. On the public payer front, inconsistencies exist. For example, Medicare's policies for coverage and payment for telehealth services lag far behind other payers due to its restrictive statutes and regulations. Many state Medicaid programs cover telehealth services to some extent, although the criteria for coverage vary widely from state to state. On the private payer side, by contrast, there has been significant expansion with many states passing laws requiring private payers to provide coverage for telehealth services.

Private Payers

According to the American Telemedicine Association (ATA), 20 states and the District of Columbia have enacted "parity" laws, which generally require health insurers to cover and pay for services provided via telehealth the same way they would for services provided in-person. Virginia and New Mexico are two states that have created a regulatory environment that encourages the availability and provision of telehealth services, including providing telehealth coverage for their state employee health plans. Two additional states – Arizona and Colorado – have enacted partial parity laws that require coverage of and reimbursement for telehealth services. However, coverage is limited to a certain geographic area or a predefined list of qualified services. [x]

Medicaid

A 2014 report by the Center for Connected Health Policy noted that 46 state Medicaid programs, both fee-for-service (FFS) and Medicaid managed care, have some form of coverage for telehealth services, such as for remote patient monitoring (13 states). Live video is the most frequently covered telehealth service, while store-and forward services are defined and reimbursed by only a handful of state Medicaid programs. State Medicaid programs rarely cover e-mail, telephone and fax consultations, unless they are used in conjunction with some other type of communication. Twenty-four states pay providers either a transmission or a facility fee, or both. A few states have adopted the Medicare policy that restricts coverage to only telehealth services that are provided in rural or underserved areas. [xi]

Medicare
Despite recent expansions in covered services, Medicare lags 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. Even within Medicare, some Medicare Advantage plans are beginning to provide telehealth benefits that are not covered under Medicare 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, including:

- Eliminating geographic and setting location requirements;
- Expanding the types of covered services (today, Medicare pays for only 75 services);
- Simplifying the process to expand the list of covered services by type instead of CPT codes; and
- Including store-and-forward and remote patient monitoring as covered services.

The committee can help address some of these issues by expanding our nation's telecommunications infrastructure. This would help specifically with:

- Expanding eligible 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 systems continue to improve, it will become increasingly possible to safely provide care to patients in other settings, including, potentially, the office, school or home.

- Expanding 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, they are not included in Medicare's telehealth policy.

Rural Health Care Program and Health Care Connect Fund Limitations

Subsidy and Usage. The FCC created the Health Care Connect Fund (HCCF) as a part of the Rural Health Care Program (RHCP) in 2012 with the goal of expanding broadband access for health care providers. The AHA urges the committee to look at these underutilized programs for ways to provide a greater benefit to health care providers. The pilot program that served as a precursor to the HCCF allowed providers an 85 percent subsidy level. The HCCF reduced the subsidy amount to 65 percent. According to a 2010 Government Accountability Office report, the RHCP program disbursed $327 million while in operation – well below the $400 million yearly cap.[xii] Funds are going unused, while providers still struggle to expand their networks. The AHA recommends the committee consider expanding the subsidy to offer reduced cost sharing for participating health care providers and to more appropriately utilize the HCCF.

Reducing the administrative burden of participation also would likely increase involvement by providers.

Limits on Hospitals – Provider Status and Capacity Limits. Current program requirements restrict access for certain types of providers. For-profit entities are an integral part of the rural health care system. For example, 12 percent of rural hospitals are for-profit. The program can clearly support additional providers, and we urge the committee to consider ways to expand participation for those for-profit entities serving vulnerable populations. The AHA also would support lifting the cap on funding for non-rural hospitals with more than 400 beds that are part of a consortium that is predominantly rural.

CONCLUSION

The AHA and the hospital field appreciate your recognition of telehealth as a vital component of the health care system of the future. However, implementation has been hampered by operational challenges. The implementation and effective use of Internet, mobile and video technologies offer hospitals, physician groups and health plans ways to improve performance and provide greater convenience and value to patients. The Rural Health Care Program, including the Health Care Connect Fund, is a critical source of support for health care providers. We appreciate the committee's consideration of proposed changes, which would greatly strengthen the program and support the advancement of telehealth. These programs need to continue to evolve to encourage provider participation through lower administrative burden, reduced cost sharing, and better compensation for program administration. We urge the committee to work toward creating a policy environment that supports these efforts and accelerates the transition to the health care system of the future.

[i] AHA Annual Survey, Health Information Technology Supplement (2013).

[ii] NTT Data, *Trends in Telehealth* (2014), available at: http://americas.nttdata.com/Industries/Industries/Healthcare/~/media/Documents/White-Papers/Trends-in-Telehealth-White-Paper.pdf.

[iii] NTT Data, *Trends in Telehealth* (2014), available at: http://americas.nttdata.com/Industries/Industries/Healthcare/~/media/Documents/White-Papers/Trends-in-Telehealth-White-Paper.pdf.

[iv] Akanksha Jayanthi. The Rise of mHealth: 10 Trends. Becker's Health IT and CIO Review (June 27, 2014), available at: http://www.beckershospitalreview.com/healthcareinformation-technology/the-rise-of-mhealth-10-trends.html.

[v] NTT Data, Trends in Telehealth (2014), available at: http://americas.nttdata.com/Industries/Industries/Healthcare/~/media/Documents/White-Papers/Trends-in-Telehealth-White-Paper.pdf.

[vi] PricewaterhouseCoopers Health Research Institute. New Health Economy (2014).

[vii] Craig M. Lilly, M.D., FCCP et al., A Multicenter Study of ICU Telemedicine Reengineering of Adult Critical Care, CHEST 145(3): 500-507 (2014), article abstract available at: http://journal.publications.chestnet.org/article.aspx?articleID=1788059.

[viii] Madan Dhamar, et al, Impact of Critical Care Telemedicine Consultations on Children in Rural Emergency Departments, CRITICAL CARE MEDICINE (2013).

[ix] Adam Darkins, "Telehealth Services in the United States Department of Veterans Affairs (2014), available at: http://c.ymcdn.com/sites/www.hisa.org.au/resource/resmgr/telehealth2014/Adam-Darkins.pdf.

[x] American Telemedicine Association, STATE TELEMEDICINE GAPS ANALYSIS:

COVERAGE & REIMBURSEMENT, available at: http://www.americantelemed.org/docs/default-source/policy/50-state-telemedicine-gaps-analysis---coverage-and-reimbursement.pdf?sfvrsn=6.
[xi] Center for Connected Health Policy, STATE LAWS AND REIMBURSEMENT POLICIES, available at: http://cchpca.org/sites/default/files/uploader/50%20STATE%20MEDICAID%20REPORT%20SEPT%202014.pdf.
[xii] FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, available at: http://www.gao.gov/new.items/d1127.pdf