American Hospital Association™
Advancing Health in America

Washington, D.C. Office
800 10th Street, N.W.
Two CityCenter, Suite 400
Washington, DC 20001-4956
(202) 638-1100

April 2, 2019

The Honorable Brian Schatz
United States Senate
722 Hart Senate Office Building
Washington, DC 20510

The Honorable Roger Wicker
United States Senate
555 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ben Cardin
United States Senate
509 Hart Senate Office Building
Washington, DC 20510

The Honorable John Thune
United States Senate
511 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark Warner
United States Senate
703 Hart Senate Office Building
Washington, DC 20510

The Honorable Cindy Hyde-Smith
United States Senate
113 Dirksen Senate Office Building
Washington, DC 20510

RE: Recommendations to improve and expand access to telehealth

Dear Senate Members of the Congressional Telehealth Caucus:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners, including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to respond to your letter requesting suggestions to improve and expand access to telehealth.

Telehealth connects patients to vital health care services through videoconferencing, remote monitoring, electronic consults and wireless communications. By increasing access to physicians and specialists, telehealth helps ensure patients receive the right care, at the right place, at the right time. Currently, 76 percent of U.S. hospitals connect with patients and consulting practitioners at a distance through the use of video and other technology. Almost every state Medicaid program has some form of coverage for telehealth services, and private payers are embracing coverage for many telehealth services.

However, there are barriers to wide adoption of telehealth. Medicare generally still limits coverage and payment for many telehealth services, lagging behind other payers. The Medicare program recently expanded coverage for telehealth services for stroke patients and substance use treatment in response to statutory changes from Congress. Medicare also expanded payments to clinicians for virtual check-ins. Limited access to adequate broadband services hampers the ability of some rural facilities to deploy telehealth. The challenge of cross-state licensure also looms as a major issue. Other policy and operational issues include credentialing and privileging, online prescribing, privacy and security, and fraud and abuse. **Overall, the AHA appreciates your focus on expanding and improving access to telehealth services for patients. The recent changes made to Medicare coverage of telehealth are promising, but more can be done to build on this progress.**

TELEHEALTH CAN IMPROVE CARE AND LOWER COSTS

Telehealth is increasingly viewed as a cost-effective method to deliver patient care and expand access. The growing use of telehealth reflects larger health care trends that place the patient's care and experience at the center of treatment decisions. However, coverage for telehealth services – especially in Medicare – has not kept pace with technological and care delivery innovations. Private payers have made more progress in recognizing the benefits of telehealth services through their coverage and reimbursement guidelines, while retail clinics are incorporating telehealth to increase convenience and patient access to doctors. As telehealth technologies evolve, it is important for Congress to understand the prospective benefits and embrace a framework that allows patients, providers and payers to incorporate technological innovations in care delivery.

The Congressional Budget Office (CBO) has long held the view that expanding access to telehealth would increase spending due to higher utilization. Specifically, CBO states "if rural or urban enrollees would otherwise not have received care because of difficulties in obtaining access to doctors, providing telemedicine might well increase spending on services Medicare covers instead of substituting for services that would have been covered without telemedicine."[1] However, CBO has significantly overestimated the cost of adopting telehealth in previous bills that became law. In 2001, Congress authorized the current limited guidelines on telehealth coverage for Medicare; CBO predicted telemedicine would cost Medicare $150 million in the first five years after the law was passed. In practice, the program has spent only $57 million on telehealth services over 14 years, according to the Center for Telehealth and eHealth Law.[2] Experts from health plans, which have incentives to ensure patients receive efficient care, have advocated for Medicare and other programs to expand telehealth coverage.

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[1] CBO Blog. Telemedicine. Congressional Budget Office. July 29, 2015. Accessed April 1, 2016. https://www.cbo.gov/publication/50680

[2] Pittman, David. Telemedicine fans point to CBO's history of cost overestimates. POLITICO. December 21, 2015. Accessed April 1, 2016.

Notably, at the February 2016 meeting of the Medicare Payment Advisory Commission (MedPAC), both commissioners representing health plans encouraged MedPAC to recommend that Medicare embrace telehealth in coverage guidelines.[3] The commissioners noted the benefits of telehealth for patients, including less time lost due to travel and greater convenience, and expressed concern that Medicare may be proceeding too cautiously on coverage of telehealth services.

Initial Telehealth Consultations Can Lead to Decreased Utilization. While improved access to care generally is viewed as positive, concerns about the long-term financing of public payer programs has led to increased scrutiny of coverage decisions that could lead to increased costs. However, research suggests these concerns may be unfounded. A study of enrollees in the California Public Employees Retirement System (CalPERS) evaluated the impact on utilization of providing physician consultations via telehealth through Teledoc, a telehealth provider. The study found that, after a telehealth visit, the patient was less likely to require a follow-up visit in comparison to individuals who received their initial consult for a similar condition in the emergency department (ED) or a physician's office. Six percent of telehealth visits resulted in a follow-up visit, in contrast to 13 percent of office visits and 20 percent of ED visits. Additionally, telehealth utilization increased during weekends and holidays, times when ED utilization typically increases due to limited access to physician offices.[4] The timing of these visits suggests that less expensive telehealth visits are potentially promising substitutes for visits to the ED.

Telehealth can Allow Patients to Receive Hospital Services at Home. Hospitals are exploring how to use telehealth for patients who are sick enough to be hospitalized but stable enough to be treated at home. Conditions with defined treatment protocols such as congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD) are well-suited to these "hospital-at-home" models. When a patient is treated at home, clinical staff travel to the home as needed to provide treatment, while telehealth is used to monitor the patient's condition and enable daily meetings with the physician.[5] These services can be especially valuable for patients who face difficulties with mobility or co-morbidities, have limited options for transportation, or would otherwise have to travel long distances to access care.

Hospital-at-home programs have been tested under partnerships with Medicare Advantage plans, private payers and the Veterans Health Administration.[6]

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[3] Medicare Payment Advisory Commission. Public session on Telehealth Services and the Medicare Program. March 3, 2016.
[4] Uscher-Pines, Lori, et al. Analysis of Teledoc Use Seems to Indicate Access to Care for Patients without Prior Connection to a Provider. Health Affairs. 33:12 (2014). http://content.healthaffairs.org/content/33/2/258.full.pdf.
[5] Johns Hopkins Medicine. A Typical Hospital at Home Program Follows These Steps. http://www.hospitalathome.org/about-us/how-it-works.php.
[6] Klein, Sarah. "Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers. The Commonwealth Fund. August/September 2011.

The hospital-at-home program, pioneered by Johns Hopkins Medicine in Baltimore, focuses on elderly patients who are unwilling to go the hospital or have compromised immune systems that would make them susceptible to healthcare-acquired infections. Results from Johns Hopkins' application of the model showed the total cost of at-home care was 32 percent less than traditional hospital care ($5,081 vs. $7,480), the mean length of stay for patients was shorter by one-third (3.2 days vs. 4.9 days), and the incidence of delirium (among other complications) was dramatically lower (9 percent vs. 24 percent).[7] A study of the program also found no difference in rates of subsequent use of medical services or readmissions, and patients and family members' satisfaction was higher in the home setting than among those offered inpatient hospital care.[8]

The hospital-at-home program at Presbyterian Healthcare Services in Albuquerque, N.M., focuses on patients with pneumonia, COPD and CHF, among other conditions. The health system found that patients using the program were more likely to receive care aligning with clinical best practices, such as fewer readmissions and falls, as well as report higher patient satisfaction. Spending on the hospital-at-home population was 19 percent lower than that for a similar patient population. The difference was attributable to shorter length of stay and lower utilization of clinical testing.[9]

Telepsychiatry Services Allow EDs to Serve Behavioral Health Patients Effectively. Hospitals have grappled in recent years with how best to provide services to patients with behavioral health needs, particularly as state financial support for psychiatric services has declined. States cut $5 billion in mental health services from 2009 to 2012, and nearly 10 percent of the total supply of public psychiatric hospital beds was eliminated.[10] As a result, many patients turn to the ED when they have behavioral health needs. However, the ED is not typically well-equipped to meet these patients' needs. In practice, an attending physician will evaluate and treat any physical issues that may be contributing to the patient's condition, and then the patient may be forced to wait an extended time before a psychiatrist is able to see him or her.[11] Telehealth can help EDs effectively assist this patient population. In fact, a 2016 JAMA study found that mental health conditions were responsible for nearly 80 percent of telemedicine visits among rural Medicare beneficiaries from 2004-2013, highlighting

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[7] https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance

[8] Klein, Sarah. "Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers. The Commonwealth Fund. August/September 2011. https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance

[9] Cryer, Lesley, et al. Costs For 'Hospital At Home' Patients Were 19 Percent Lower, With Equal Or Better Outcomes Compared To Similar Inpatients. Health Affairs 31:6 (2012). https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2011.1132.

[10] Szabo, Liz. Cost of Not Caring: Nowhere to Go. USA Today. May 12, 2014. Accessed April 1, 2016. https://www.usatoday.com/story/news/nation/2014/05/12/mental-health-system-crisis/7746535/

[11] Interview with Dignity Health, March 21, 2016.

both the scarcity of behavioral health specialists in rural communities and the potential for virtual strategies to address these pressing service needs.[12]

Telepsychiatry services have allowed Dignity Health, a health system based in San Francisco, to provide appropriate care quickly and cost effectively. For patients who do not pose an immediate threat to themselves or to others and who may not be candidates for discharge, the hospital typically connects the patient to a psychiatrist through telehealth within 90 minutes from arrival at the ED. This reduction in elapsed time between arrival at the ED and interaction with a specialist is essential, as behavioral conditions can deteriorate during the time that a patient waits to see a psychiatrist. The psychiatrist is then able to recommend whether the patient should be discharged, transferred, or further observed, and any needed follow-up care. This process has helped Dignity reduce the number of behavioral health patient admissions and, more importantly, provide care to patients quickly.[13]

Private Plans and Retail Clinics Making Investments in Telehealth. Policymakers and regulators also can look to the private sector for evidence that at-risk plans and publicly traded companies see the value of telehealth through their coverage and deployment strategies. Private insurersare rapidly incorporating telehealth into their Medicare Advantage, commercial and individual benefit packages, including physician telehealth visits in both urban and rural areas. Most other major commercial insurers and self-insured employers are incorporating some type of telehealth benefit into their coverage.[14] In 2015, CVS Health engaged three telehealth companies to expand patient access to doctors for online or over the phone consultations in six states. Prior to this official rollout, CVS conducted an 18-month pilot program in California and Texas. Of 1,700 patients who were surveyed in the pilot program, 95 percent were highly satisfied with the quality of care they received, the ease of using the technology and the timeliness and convenience of the care. In addition, one-third of patients indicated they preferred a telehealth visit to a visit with a clinician in the same room.[15] Telehealth visits provided in this manner alleviate the need for patients to wait in-person at an urgent care clinic, an important differentiator as consumers increasingly cite convenience as a key driver in their health care treatment decisions.[16]

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[12] Mehrotra A., Jena A B., Busch A B., Souza J., Uscher-Pines L., and Landon B E. (2016 May 10) Utilization of Telemedicine among Rural Medicare Beneficiaries.Jama Network. Retrieved from: https://jamanetwork.com/journals/jama/fullarticle/2520619

[13] Dignity Health Telemedicine Network. Telemental Health: Emergency Department Program Overview.

[14] 3 Herman, Bob. Virtual Reality: More Insurers are Embracing Telehealth. Modern Healthcare. February 20, 2016. http://www.modernhealthcare.com/article/20160220/MAGAZINE/302209980

[15] 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-six-states.html

[16] 5 PriceWaterhouseCoopers. The Top Health Industry Issues of 2015: Outlines of a Market Emerge. December 2014.

AHA Recommendations to Increase Telehealth Access and Coverage

The AHA supports the expansion of patient access created by hospitals and health systems' efforts to deliver high-quality and innovative telehealth services. Specifically, we would appreciate Congress taking actions to:

- Expand Medicare coverage.
- Resolve legal and regulatory challenges.
- Increase federal research regarding the cost-benefits of telehealth and add flexibility in new payment models.
- Improve the Federal Communications Commission (FCC) Rural Health Care Program.

Expand Medicare Coverage. Limited Medicare coverage impedes the expansion of telehealth services. Current statute restricts most telehealth services to patients located in rural areas and in specific settings (such as a hospital or physician office), covers only a limited number of services, and allows only real-time, two-way video conference capabilities, with limited exceptions, such as telestroke. Changes needed include: widespread elimination of geographic and setting locations' requirements so patients outside of rural areas can benefit from telehealth; expanding the types of technology that can be used, including remote monitoring; and covering all services that are safe to provide, rather than a small list of approved services.

- **Geographic restrictions.** By statute, Medicare only will 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) also can 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.[17]

- **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). As of calendar year 2019,

[17] AHA Trendwatch, January 2015, https://www.aha.org/system/files/research/reports/tw/15jan-tw-telehealth.pdf

only 98 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. In addition, the facility fee that originating sites receive is marginal compared to the overall costs of providing telehealth services. The Center for Medicare and Medicaid Innovation (CMMI) is currently testing cost-based reimbursement for originating sites in several frontier communities, and preliminary findings indicate that this payment model has helped with access to services.[18] **The AHA urges federal payers to cover the cost of providing telehealth at the originating site.**

- **Practitioner location (distant site).** While the Medicare statute does not specify which facilities may serve as distant sites, the Centers for Medicare & Medicaid Services (CMS) has excluded rural health clinics and federally qualified health centers. **The AHA supports lifting these restrictions to allow these providers to serve as both originating and distant sites.**

- **Approved technologies.** Medicare only may 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, except in limited circumstances.

- **Resolve legal and regulatory challenges**. Significant federal and state legal and regulatory issues will determine whether and how providers can offer specific telehealth services. In general, the provision of telehealth services requires compliance with an array of federal and state rules. Legal and regulatory challenges abound in the following areas:

    - **Coverage and payment**. Coverage by public and private payers varies significantly and whether payers cover and adequately reimburse providers for telehealth services is a complex and evolving issue. Adequate reimbursement and revenue streams are necessary in order for

[18] U.S. Department of Health and Human Services. September 2018. Demonstration project on community health integration models in certain rural counties. Interim Report to Congress. https://www.hrsa.gov/sites/default/files/hrsa/ruralhealth/reports/FCHIP-Interim-Report-September-2018.pdf

providers to invest in these technologies, especially those that serve vulnerable rural and urban communities – where the need for these services may be the greatest.

- **Health professional licensure, credentialing and requirements.** State licensure laws can be major obstacles for facilities wanting to provide telehealth services to patients in other states because of the current lack of portability of health professional licenses between states. Credentialing and privileging requirements also may be problematic because telehealth services usually involve multiple health care facilities that must each credential and privilege the practitioner(s) providing care. Because some state laws limit the composition of hospital staff, opportunities to leverage expertise from certain distant sites can be restricted. The harmonization of state laws to foster increased physician licensure portability, greater licensure portability for nurse practitioners, physician assistants and other health professionals, increased flexibility of the physical examination requirement for online prescribing and clarification of medical malpractice insurance rules for telehealth encounters would facilitate the adoption of telehealth.

- **Privacy and security.** Generating, sharing and storing electronic health information can create some additional operational challenges for health care providers in meeting their existing privacy and security obligations under the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH) and any relevant state privacy laws. Health care providers will need to understand the intricacies of existing legal and regulatory requirements for safeguarding the privacy and security of a patient's medical information in the context of telehealth. More uniformity among federal and state laws and regulations in these areas would help facilitate adoption of virtual care strategies.

- **Fraud and abuse.** Telehealth relationships must comply with applicable federal health care fraud and abuse laws, such as the False Claims Act. Arrangements between independent providers (e.g., physician collaborations with institutional providers and/or technology companies) may be subject to the Anti-Kickback statute and/or the Stark Law physician self-referral prohibitions. The potential for exposure to liability under various federal fraud and abuse laws only will increase as telehealth becomes more widespread. More uniformity among federal and state fraud and abuse standards would help facilitate adoption of the telehealth services.

Increase Federal Research on the Cost-benefits of Telehealth and Add Flexibility in New Payment Models. Additional research is needed to evaluate telehealth.

Research and experience under the Medicare program suggest that policymakers' concerns about increased access to telehealth leading to increased spending may be overstated, particularly when weighed against the potential benefits in quality, patient experience and efficiency. However, there are insufficient studies on the cost-benefits of telehealth outside of a limited number of services, such as telestroke. More and better research is needed for other conditions and newer technologies, such as remote monitoring of patients.

The health care field is quickly moving from fee-for-service to a value-based delivery system. Success in new payment models, such as bundling, accountable care organizations (ACOs) and new physician payment models requires flexibility to deploy telehealth, particularly as part of care management programs. CMS has shown some willingness to provide waivers and Congress has expanded the ability of some ACOs to use telehealth, but only in limited circumstances. CMS should include telehealth waivers in all of its demonstrations and adopt a more flexible approach to adding new telehealth services to Medicare. In CMS's 2018 Rural Health Strategy, the agency identified incorporating "telehealth flexibilities" in CMMI models and "modernizing and expanding telehealth through CMMI models and demonstrations" as key supporting activities for meeting rural health objectives.[19]

Improve the FCC's Rural Health Care Program. Federal programs to expand broadband need to be simplified. According to the FCC, 34 million Americans still lack access to adequate broadband. And, there is a large digital divide, with nearly 40 percent of those living in rural areas lacking access. The FCC's Rural Health Care Program supports broadband adoption, but it is administratively burdensome and provides an insufficient level of subsidy for remote health care providers. While the FCC has taken positive steps by increasing the subsidy cap, and proposing a Connected Care Pilot, we need even greater federal investment in broadband access, particularly in rural areas. In addition to broadband, investments also are needed for equipment and training in order for telehealth to be truly effective in rural communities.

CONCLUSION

A growing body of evidence shows that telehealth can expand access to services and create cost savings. For many patients, telehealth increases the ability to access timely care while reducing the potential inconvenience of travelling long distances or being transferred to another health care facility. However, additional research into telehealth, using larger samples sizes, diverse geographies and a broader range of conditions and services, could provide Congress with a better understanding of the full range of benefits that telehealth can yield in providing care in more efficient and cost-effective ways. The Agency for Healthcare Research and Quality Telehealth Evidence Map states that "future research should help providers and health systems differentiate the

[19] Centers for Medicare & Medicaid Services. May 2018. CMS Rural Health Strategy. https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf

value of telehealth services as an addition to traditional in-person care, and the value of telehealth as a replacement for in-person care."[20] Additionally, the inclusion of telehealth in value-based payment models can help assess the value of telehealth in situations where financial incentives promote quality improvement and cost savings. Finally, geographic limitations on telehealth use should be lifted, as patients regardless of care setting or physical location can benefit from increased access to expert physicians that can promote adherence to treatment plans that reflect the latest clinical best practices. Research and experience under the Medicare program suggest that concerns about increased access to telehealth leading to increased spending may be overstated, particularly when weighed against the potential benefits in quality, patient experience and efficiency. In fact, when the right types of services are utilized at higher levels, cost is significantly reduced. By modernizing Medicare coverage of telehealth, including telehealth services in innovative payment models, and committing additional resources to understanding the patient and cost benefits of telehealth, Congress can advance the delivery of care and benefit patients.

The AHA and the hospital field appreciate your recognition of telehealth as a vital component of the health care system of the future. We urge the committee to work toward creating a legislative proposal that accelerates the transition to the health care system of the future. The AHA greatly appreciates your leadership in this area and the opportunity to provide input. We look forward to continued discussion of this important policy issue.

Please contact me if you have questions or feel free to have a member of your team contact Kristina Weger, executive director, executive branch relations, at kweger@aha.org or (202) 626-2369.

Sincerely,

/s/

Thomas P. Nickels
Executive Vice President

[20] Agency for Healthcare Research and Quality. Telehealth: Mapping the Evidence for Patient Outcomes from Systematic Reviews. June 2016. Accessed April 1, 2019. https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/telehealth_technical-brief.pdf.