Dear Congressional Telehealth Caucus:

The Advanced Medical Technology Association (“AdvaMed”) appreciates the opportunity to provide information in response to your March 12, 2019 letter requesting policy recommendations to improve access to telehealth services. AdvaMed represents manufacturers of digital health technologies, medical devices, and diagnostic products that are transforming health care through earlier disease detection, less invasive procedures, and more effective treatment. Our members range from the smallest to the largest medical technology innovators and companies.

AdvaMed member companies have been engaged in the development of a variety of digitally-based medical technologies that have begun to transform health care, improving both the efficiency of care delivery as well as patient care outcomes. We believe that we are only at the very earliest stages of seeing the benefits and promise of digitally-based medical technologies for improving health care. We expect to see a wide-range of new health care-related digital technologies introduced in the coming years leading to even greater improvements and savings in health care—if public and private payer health programs recognize these benefits in their coverage and payment policies.

Recently Congress saw the need to go beyond the limitations and restrictions of Medicare’s telehealth benefit by enacting in BBA 2018 and H.R. 6 targeted and focused expansions of Medicare’s benefit to provide greater access to telehealth services for certain categories of patients in certain settings. We believe that additional opportunities exist for other targeted and limited expansions in Medicare’s telehealth benefit and we discuss those below. To the extent telehealth services are not covered by Medicare, the proven benefits of many telehealth technologies, the upfront investment, and ongoing implementation costs of telehealth create a disincentive to use these technologies at a time when cost pressures and restricted budgets limit the ability to do so.

In the Physician Fee Schedule for CY 2019, we saw CMS taking a leadership role in expanding access to technology-based remote patient monitoring services—that are distinct from telehealth services—by recognizing new codes for which physicians and other practitioners may be paid for their work and expense in providing remote patient monitoring services through a variety of technologies. We hope the agency continues to show leadership in this area as new technologies, such as artificial or augmented intelligence, come on line.

Other digitally-based technologies have started to become available for health care conditions—advanced diabetes technologies are a good example—that have experienced significant challenges to coverage and payment under Medicare. Many of these digitally-based technologies do not fit clearly into an existing Medicare benefit category, either because Medicare’s benefit structure largely reflects the state of health care delivery at the time the
program was created in 1965, or because CMS regulations implementing the benefit categories make it difficult or even impossible to cover the technologies, for example, those using a smart device, an algorithm, or an app. We assume you are acquainted with the recent tortured coverage decision process CMS went through to begin to allow persons on continuous glucose monitoring for diabetes management to use, only occasionally, a smart device for monitoring their glucose levels. Medicare beneficiaries will be denied access to new digitally-based technologies that will improve their health, and the Medicare program will be denied savings from improvements in care delivery efficiencies and reductions in use of many other health care services, if these structural and regulatory barriers are not addressed and overcome.

We would appreciate the opportunity to work with the Caucus on all of these issues and problems and to share our ideas for solving some of these problems.

The Telehealth Problem

As you know, current law restricts access to telehealth services and telehealth technology, limiting opportunities to reduce costs and improve the quality of care for Medicare beneficiaries:

- **Geographic restrictions:** Coverage of telehealth services is generally limited to individuals that are in an “originating site” located in a rural health professional shortage area, and in a county that is not a Metropolitan Statistical Area.

- **Originating sites:** Originating sites are limited to the following that also first meet geographic restrictions: the office of a physician or practitioner; a critical access hospital; a rural health clinic; a federally qualified health center; a hospital; hospital-based or critical access hospital-based renal dialysis center (including satellites); skilled nursing facility; community mental health center. In most cases, the beneficiary’s home is not considered an “originating site” under current law.

- **Providers:** Covered services may be provided by a narrow-defined set of professionals including physicians, nurse practitioners, physician assistants, clinical psychologists, etc. Telehealth services provided by physical therapists, occupational therapists, speech audiologists, etc. are not covered.

- **Technology:** Telehealth services must involve an interactive audio and video telecommunications system that permits real-time communication between the provider and the beneficiary. Asynchronous “store and forward” technology is permitted only in Alaska or Hawaii. A number of years ago, CMS distinguished telehealth services from remote monitoring services, which can also be technology-based services, by assigning distinct codes to individual services covered in each category.

There is strong support for expanding telehealth services. The Medicare Payment Advisory Commission (MedPAC) in particular has recommended expansion of certain telehealth services. In its March 2018 report to Congress, MedPAC set out 3 principles for evaluating the value of telehealth services for potential expansion under Medicare: cost, access, and quality of care. It
evaluates the existing literature and evidence for specific categories of telehealth services in terms of these principles. MedPAC identified examples where evidence was clear to suggest coverage expansion: Telestroke; expansion of telehealth services to beneficiaries with physically disabling and treatment-intensive conditions and living in urban areas or the patient’s home; and expanded coverage through Medicare Advantage and Accountable Care Organizations.

Unfortunately, expansion of telehealth and remote monitoring services has been hampered by the Congressional Budget Office (CBO) view that there is a lack of evidence to demonstrate savings through expansion of telehealth services. Both CBO and MedPAC recommended that expansion of telehealth services be tested to generate official government data and evaluate potential impacts on health care spending in the Medicare population.

**Recommendations**

AdvaMed recommends the following areas for targeted and focused expansion of Medicare’s existing telehealth benefit:

1. **Require that CMS/CMMI analyze data from alternative payment models where waivers have allowed expansion of coverage of telehealth services to determine impact of services on the cost, quality, and outcomes of care comparing persons with access to expanded services with those without access.** Data analysis could focus on particular chronic conditions that APMs have targeted expanded coverage on. This data analysis would address the concern of government agencies (CMS, CBO, MedPAC) that available literature and evidence do not make a clear case for the cost savings and quality improving impact of telehealth services. The findings of the evaluator would also serve as the basis for defining circumstances when Medicare’s telehealth benefits would be expanded. For those services determined to have a positive impact on cost and clinical outcomes, CMS/CMMI should evaluate whether any barriers exist under existing payment systems (e.g., start-up and infrastructure costs) and consider recommendations to address those barriers to ensure access.

2. **Waive the geographic (rural) limitations of the benefit to allow telehealth services to be covered in urban hospital emergency departments (EDs).** Nearly three quarters of the Medicare population live in non-rural areas and are not eligible for coverage of emergency department telehealth services. Telehealth in the ED can bridge the gap to provider specialists who can quickly assist in the diagnosis and treatment of Medicare beneficiaries but who are not available at the time the patient presents in the ED. Current Medicare policy limits access to telehealth services only to those living in rural geographic locations.

3. **Waive the geographic (rural) restrictions of the benefit to allow tele-mental health services to be provided in urban areas.** As MedPAC pointed out in its 2018 report, mental health services can be a good match for telehealth since mental health services largely do not require the clinician to have physical contact with the patient. In addition, tele-mental health services are among the most commonly used telehealth services by Medicare beneficiaries living in rural areas. HHS has documented shortages for all types
of mental health clinicians and projects that these shortages are expected to increase in the future. Waiving the geographic restriction for these services may provide urban beneficiaries access to services they currently lack because of shortages of mental health professionals. In light of the current opioid health crisis, we also recommend that tele-mental health services include addiction and pain management services.

4. Allow physicians licensed in one state to provide telehealth services to a Medicare beneficiary residing in another state where the distant physician is not licensed to provide care. This exemption to State licensure law would provide enhanced access to care for beneficiaries and would apply only to Medicare beneficiaries.

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Thank you for the opportunity to provide input on this important topic and we look forward to continuing to work with you and your office. Should you have any questions, please do not hesitate to contact me at 202-434-7227 or rprice@advamed.org.

Respectfully submitted,

/s/

Richard Price
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